Washington State Comprehensive Mental Health Plan

*** D R A F T ***

September 30, 2006

Washington's Mental Health Transformation Project
Partnerships for Recovery & Resiliency

Mental Health Transformation State Incentive Grant

Comprehensive Mental Health Plan for the STATE OF WASHINGTON

D R A F T

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Presentation to the Mental Health Task Force
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TWG Meeting Handouts
Vision, Goals, and Objectives
Subcommittee Reports
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Task Group Presentations and Supplemental Reports, Documents
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MHTP Participants and Contributors

TWG members and alternates
Subcommittee Members
Task Group Members
Research Committee Members
Contractors

List of MHTP-related Meetings

Framework for a Coordinated Mental Health System

Mental Health from a Public Health Perspective: Presentation to the Mental Health Transformation Working Group, April 21, 2006

Mental Health Framework Circles Expanded

What is mental health?

ACRONYMS

ADSA	Aging and Disability Services Administration, Department of Social and Health Services
CA	Children's Administration, Department of Social and Health Services
CAMIS	Case and Management Information System
CIT	Crisis Intervention Team
CLIP	Children's Long-Term Inpatient Program
CMHC	Community Mental Health Center
CMHP	Comprehensive Mental Health Plan
CMHS	Center for Mental Health Services
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CMS	Centers for Medicare and Medicaid Services
CODIAC	Co-Occurring Disorders Interagency Committee
CSDB	Client Services Database
CTED	Department of Community, Trade, and Economic Development
CTP	Community Transformation Partnership
CSDB	Client Services Database
DASA	Division of Alcohol and Substance Abuse, Department of Social and Health Services
DOC	Department of Corrections
DOH	Department of Health
DSHS	Department of Social and Health Services
DVR	Division of Vocational Rehabilitation, Department of Social and Health Services
EBP	Evidence-Based Practice
EBPEP	Evidence-Based/Promising/Emerging Practices Task Group
ECCS	Early Childhood Comprehensive Systems
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ESA	Economic Services Administration, Department of Social and Health Services
ESD	Employment Security Department
FACET	Family and Consumer Evaluation Team
GPRA	Government Performance and Results Act
HIIS	Health Integrated Information System
HRSA	Health and Recovery Services Administration, Department of Social and Health Services
ICCD	International Center for Clubhouse Development
IPAC	Indian Policy Advisory Committee

JRA	Juvenile Rehabilitation Administration, Department of Social and Health Services
MHD	Mental Health Division, Department of Social and Health Services
MHD-CIS	Mental Health Division–Consumer Information System
MHPAC	Mental Health Planning and Advisory Committee
MHSIP	Mental Health Statistics Improvement Project
MHTP	Mental Health Transformation Project
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NAMI	National Association for the Mentally Ill
NOMS	National Outcome Measures
NPAIHB	Northwest Portland Area Indian Health Board
OCA	Office of Consumer Affairs, Department of Social and Health Services, Mental Health Division
ORCA	Outreach for Recovery and Consumer Advocacy
OSPI	Office of the Superintendent of Public Instruction
PACT	Program for Assertive Community Treatment
PAS	Personal Assistance Services
PIHP	Pre-paid Inpatient Hospital Plan
PTSD	Post-Traumatic Stress Disorder
RCW	Revised Code of Washington
RDA	Department of Social and Health Services, Division of Research and Data Analysis
ROSI	Recovery Oriented System Indicators
RSN	Regional Support Network
SAFE-WA	Statewide Action for Family Empowerment in Washington
SAMHSA	Substance Abuse and Mental Health Services Administration
SDC	Self-Directed Care
SMHA	State Mental Health Authority
SRDG	Social Research Development Group
TWG	Transformation Work Group
WAC	Washington Administrative Code
WASPC	Washington Association of Sheriffs and Police Chiefs
WDVA	Washington State Department of Veterans Affairs
WIMIRT	Washington Institute for Mental Illness Research and Training
WRAP	Wellness Recovery Action Plan
WSPY	Washington State Partnerships for Youth
YSPP	Youth Suicide Prevention Program

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As chair of the Transformation Work Group (TWG), I would like to thank all the members of the TWG for their time and commitment to this important topic.

On behalf of the TWG, I offer our gratitude to the Joint Legislative and Executive Task Force on Mental Health Services and Financing, and in particular co-chairs Representative Eileen Cody and Senator Linda Evans-Parlette who, through their leadership and energy, were responsible for the creation of the Task Force.

We are deeply grateful to all the members of the TWG subcommittees, and task group members who devoted tremendous amounts of time, expertise and energy to developing the framework for the future of the transformation grant project. In particular, we would like to thank the chairs of these groups for their leadership and vision to this project.

Thank you to all the individuals and organizations who participated in the resource inventory and needs assessment for providing their insights and perspectives on the current state of the system of mental health services in Washington.

Thanks also to the MHTP team: Ron Jemelka, David Brenna, Erin Peterschick, Joyce Layne-Jordan, Jill San-Jule, Jeanette Barnes, Darci Ebinger, Angela French, Stephanie Lane, and Ginger Stewart. Each of these individuals played a critical role in bringing this project to fruition.

To those consumers, family members, service providers and others who testified, submitted feedback, or volunteered their time, our sincerest thanks for taking the time to share with us your visions and hopes for mental health transformation.

We also want to thank the contractors who conducted surveys and interviews, as well as analyzed, the mountain of input gathered throughout this past seven months. And Sterling Associates, who worked tirelessly to meet our timeline for completing this report.

Finally, I would like to thank Governor Christine Gregoire and her staff for championing this important effort and for taking a strong stand for the future of mental health services in our state.

Ken Stark, Director

Mental Health Transformation Project

Office of the Governor

EXECUTIVE SUMMARY

WASHINGTON STATE COMPREHENSIVE MENTAL HEALTH PLAN SEPTEMBER 30, 2006

The mental health community in Washington State envisions that all people in Washington who experience mental health challenges will lead happy, productive and fulfilling lives, free of stigma, in a safe and least restrictive environment. Since the Mental Health Transformation Grant was awarded to Washington State in October 2005, the Transformation Work Group (TWG) and its partner agencies have been working to develop a shared understanding and common agenda for the transformation of Washington's system of mental health services. The results of those efforts form the foundation for this Comprehensive Mental Health Plan (CMHP).

Using the President's New Freedom Commission goals as a framework for action, we have engaged in a broad public process to develop a roadmap for achieving a transformed mental health system. Chapter 1 describes Washington's transformation activities, as they relate to the six federal goals, and two additional Washington-specific goals added by our state's TWG.

Year One – Focus on Organizing for Transformation and Public Input

Year One of the grant has focused on gathering broad-based public input on the strengths of the current system and defining a vision for what a transformed mental health system will look like. Chapter 2 describes in detail the governance and organization structure established to carry out this work. The TWG appointed seven subcommittees comprised of consumers, families, and representatives of the mental health system to examine the strengths and weaknesses of the mental health system on specific populations: children, youth and families; youth in transition; adult consumers and families; older adults; homeless; co-occurring disorders; and criminal justice.

Input gathered from outreach efforts (including over 40 public input sessions and RSN listening sessions) was used by the subcommittees to define what outcomes a transformed system should be designed to achieve. The 27 priority outcomes identified by the subcommittees each correspond to one or more of the President's goals and are discussed in greater detail in Chapter 1.

Task groups, comprised of subject matter experts, then developed specific strategies for achieving these outcomes. Task groups focused their work in six areas: fiscal systems; information technology; evidence-based, promising and emerging practices; cultural competence; evaluation; and social marketing. These outcomes and strategies provide the framework for Washington's transformation activities for the next four years of the Mental Health Transformation Grant.

The strategies defined through this process are wide-ranging. Some address discrete short-term needs, others are long-range, conceptual and visionary. Members of the task groups will continue to work with the TWG in Year 2 to assess the financial and organizational feasibility of the strategies, and to establish priorities among the strategies. The TWG confirmed its support for the overarching principles and most of the strategies defined by the task groups. In a small number of cases, the TWG deferred action awaiting further definition. The TWG also adopted two goals in addition to the six outlined by the New Freedom Commission to address Washington's commitment to assuring meaningful employment and secure housing for consumers and their families.

The Mental Health Transformation Project (MHTP) team is working now with partner agencies to identify current or planned activities that move the transformation agenda forward. In particular, staff are reviewing state agency strategic plans recently submitted to the Governor to determine where state activity is already underway, and where gaps exist that will need to be addressed.

State agencies are currently developing budget requests and proposed legislative packages for the 2007-2009 budget period. By September, the agencies will submit these requests to the Governor's Office. Because of the need to finalize the CMHP by early September, these budget/legislative requests will not be included in the first year's plans. Once we know what is incorporated into the Governor's legislative package, and which items are supported by the Legislature, a more accurate gap analysis can be conducted. Once that is complete, the state will have a better idea where to focus its resources to address community recommendations.

Mental Health in Tribal Nations

The TWG has been working with Washington tribes on a Government-to-Government basis, to ensure that mental health transformation extends into Tribal communities. The MHTP developed a parallel process providing Tribal input, tribal outcomes and strategies, with the support of the American Indian Health Commission, the Department of Social and Health Services, and Health Services Indian Policy Advisory Committee, and through a contract with the Northwest Portland Area Indian Health Board (NPAIHB). A report on the outcomes of this effort is provided in Chapter 3.

Year Two – Facilitating the Implementation of Transformation

It is apparent that years of funding services for the most in need has created a mental *illness* system; not a mental *health* system. In Year 2, the TWG will engage all transformation partners in a crucial discussion about how and when a systemic redesign of the system of providing mental health services in Washington will occur.

If we are to achieve our objectives related to improving the health of all individuals and families residing in Washington State, we must have a strong vision. The TWG agrees with the vision of making Washington State the healthiest state in the nation and we believe Washington State must place more emphasis on prevention and early intervention as well as cross-system planning to improve the health of our residents.

Our subcommittees' work reflects that our current system of care, while expensive, is inadequate. In response they have thoughtfully articulated a strong set of recommendations for addressing the shortcomings of the current system.

The Transformation Project will pursue a dual approach, one track seeking improvements to the existing system, as recommended by the subcommittees; and concurrently they will seek to enhance the system built around illness with a system designed to support prevention and health promotion. True transformation can only occur if we do both. A more detailed discussion of prevention and mental health in Washington is contained in Chapter 4.

Reviewing the work of the past year, six major forward-looking themes have emerged that will guide the work of the MHTP in Year 2 and beyond.

Transformation Theme 1: The state of Washington views mental health as part of overall health.

Transformation Theme 2: Mental health is incorporated into existing prevention and early intervention initiatives and more coordination occurs among these programs.

Transformation Theme 3: Following the lead of the Washington Health Foundation, state agencies, with leadership from the Governor, Legislature and Superintendent of Public Instruction, will develop a core set of benchmarks (outcome measures) to track the health of Washington state residents.

Transformation Theme 4: State agencies will increase opportunities for their consumers/families/youth to establish agency priorities and direction.

Transformation Theme 5: State agencies will improve cross-system data collection, data analysis and data reporting systems that focus not only on outputs but report on actual outcomes-reductions in negative consequences and improvements in overall consumer/family/youth/ community health indicators.

Transformation Theme 6: State agencies, local government, providers, advocates, consumers, and families will make every effort to implement and improve the specific recommendations of the subcommittees. Cross-system collaborations that focus not only on symptoms, but on citizens overall health, wellness and recovery must be paramount if the system is to improve, and we are to reduce negative consequences and improve the lives of our consumers, family members, and our communities.

EVALUATING TRANSFORMATION IN WASHINGTON

Chapter 5 provides a detailed discussion of Washington's plan for evaluating the transformation effort. The primary purpose of evaluation in this project will be to provide information useful to managing the Transformation and to hold those involved accountable to the outcomes specified in this plan. Secondly, the evaluation has been designed to ensure accountability to SAMHSA for performance and outcomes of the Initiative.

NEXT STEPS

The role of the TWG in the next phases of the MHTP will shift. The TWG will not, itself, implement transformation. It will be up to the partner agencies to take up the challenge of incorporating transformational activities into their own planning and implementation. Over the next year and beyond, the TWG and the MHTP staff will refocus their efforts to provide facilitation, coordination and support to participating agencies in their efforts to translate the vision into concrete actions.

State agencies will need to modify their existing strategic plans, given Transformation priorities, and establish detailed implementation plans. These detailed plans can then be used for measuring our progress in the future.

INTRODUCTION

The state of Washington Mental Health Transformation Project (MHTP) team is pleased to submit the 2006 Comprehensive Mental Health Plan (CMHP). This plan represents the tireless work of hundreds of individuals – youth and adult consumers, family members, local and state agency staff, public and private service providers, researchers, law enforcement, and others – who have given of their considerable talents, time and insights over the past year.

BACKGROUND

While the consumer movement that ultimately lead to Washington State's transformation activities is decades old, the transformation grant process is the direct result of the President's New Freedom Commission. In April, 2002, President Bush signed Executive Order 13263 establishing the New Freedom Commission on Mental Health to study problems and gaps in the mental health system and make concrete recommendations that federal, state, and local government, as well as public and private health care providers could implement. In July, 2003, the NFC issued its report *Achieving the Promise: Transforming Mental Health Care in America*.

Washington's transformation grant was awarded in October, 2005. The grant calls for transformation to occur over the next four years.

Much of the past year has been devoted to developing a shared understanding and common agenda for transformation. It is our vision that all people in the state of Washington who experience mental health challenges will lead happy productive and fulfilling lives, free of stigma, in a safe and least restrictive environment. We have engaged in a broad public process to develop a roadmap for achieving this vision. We are ready for change.

HISTORY OF MENTAL HEALTH POLICY IN WASHINGTON: What has led to our readiness to change?

The overriding mental health policy issue since the mid-1980s has been the escalation of health care costs, which led to the transition from block grant and fee-for-service payment models for funding mental health care delivery to managed care strategies. Rapid growth in the mental health system prompted concerns that the system was fragmented and not expanding in a coordinated, responsive manner. To address the issue of

fragmentation, the legislature passed the Mental Health Reform Act in 1989. This act created county-based Regional Support Networks (RSNs) to design and administer local mental health services to meet the unique needs of people with mental disorders. Although the RSNs addressed the issue of coordination of outpatient and state hospital care, until 1993 they did not have the tools to manage care and to control the escalating costs of the Medicaid program.

Washington has moved progressively closer to a managed care model with the implementation of outpatient managed health care services for people covered by Medicaid under a federal waiver in 1995. Under this approach, Washington State purchases outpatient services through capitated payments to the RSNs and RSNs operate prepaid inpatient health plans by assuming financial risk to provide all medically necessary outpatient community mental health rehabilitation services to people in their geographic region.

In this system, RSNs serve as system integrators and primary purchasers of services in a comprehensive managed mental health care plan – they oversee every aspect of the mental health care being provided for participants and their families in their respective regions. The Mental Health Division (MHD) of the state's Department of Social and Health Services (DSHS) contracts with RSNs to ensure these services are available to residents of the region, using a combination of Medicaid, legislatively allocated state dollars, and federal block grant funds. RSNs, in turn purchase specific services directly from local providers, such as community mental health centers. Prior to the creation of RSNs, the state purchased a variety of services from a wide range of provider organizations, many of which have historically worked independent of each other and of the state.

In addition, RSNs (contracted through the MHD) have a statutory responsibility to serve the most severely disabled. As a result, mental health agencies at times must purchase mental health services outside the RSNs when the consumer needing services does not meet the threshold of disability required to receive them.

Today, Washington State's mental health system has the responsibility to serve different populations at different levels of service. Eligibility for services and the mix of services available varies depending on which state agency is funding the services. State residents eligible for Medicaid benefits must be provided medically necessary mental health services. Other people with serious mental illness are provided services as non-Medicaid resources allow.

Throughout this modern period of reform, a number of issues have caused the public mental health system to reach the point of crisis. These include:

- A lack of consistent, strong leadership at the state and local levels;
- Inadequate oversight of contracts at all levels, resulting in poor accountability;
- A lack of clarity from the federal government regarding Mediciad rules.
- Inadequate strategic planning that coordinates with key stakeholders such as local government, providers, consumers/families, research community, and allied fields.
- Limited cross-system planning among state agencies.

These issues have led to a fragmented system with credibility problems among the very stakeholders that must partner for the system to be effective. Compounding this problem, significant budget shortfalls and financial crises occurred, owing in large part to the state's recent history of heavy reliance on Medicaid funds to finance public mental health care, and state level interpretation of Medicaid funding policies that conflicted with federal interpretations. This period was marked by a growing distrust among stakeholders, and a general lack of confidence that the state's primary agency for mental health services, on its own, or the RSNs themselves, could solve these problems.

RECENT DEVELOPMENTS: The Joint Legislative and Executive Task Force on Mental Health Services and Financing

The Joint Legislative and Executive Task Force on Mental Health Services and Financing (the task force) was established during the 2004 Legislative session in order to carefully examine these issues affecting the delivery of public mental health services. The task force began their meetings in June 2004. At the last meeting of the task force prior to the 2005 legislative session, final findings and recommendations were offered. During the 2005 regular legislative session, the task force's recommendations helped shape legislation that addressed many of the issues brought before the task force.

Engrossed Second Substitute House Bill (E2SHB) 1290: Restructuring of the RSNs and New Procurement Processes

With the passage of E2SHB 1290, the legislature wanted to strengthen the public mental health system so that people experiencing mental illness receive treatment and support services focused on resilience and recovery, ideally within their own communities. The legislation is a move toward a statewide system that supports consumers to be able to live, work, learn, and participate fully in their own recovery from mental illness.

E2SHB 1290 promotes public policy that focuses on mental health treatments and services that are evidence and research-based (meaning they are programs or practices that have demonstrated results in clinical trials or have some research demonstrating effectiveness but do not yet meet the standards of evidence-based practices [EBPs].) The legislation also aims to ensure public mental health services are delivered efficiently, effectively, and consistently across the state. Coordination of services is emphasized and includes state agencies outside of DSHS. Such coordination will also, to the maximum extent possible, include consumers/youth/ families and advocates of persons with mental illness.

The task force also directed DSHS to pursue the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Transformation Grant. The collaboration between the legislative and executive branches on this task force ultimately resulted in Governor Gregoire establishing the Partnerships for Recovery and Resiliency Initiative.

Engrossed Second Substitute Senate Bill (E2SSB) 5763: Omnibus Substance Abuse and Mental Disorder Treatment Act

Also enacted in the 2005 Legislative Session, E2SSB 5763 integrated treatment of co-occurring mental and substance disorders to achieve successful outcomes and recovery through a series of changes to previous mental health and substance abuse screening and treatment policies and practices. The legislation also authorized pilot projects to test changes to the chemical dependency and mental health involuntary treatment laws, in hopes of better channeling appropriate referrals into each system of care.

One unique aspect of this legislation is that it grants county governments authority to add one tenth of one percent to the sales tax. The revenues from this additional tax can be used to fund mental health, substance abuse, and therapeutic courts. Thus far, four counties have adopted this tax.

TRANSFORMING WASHINGTON'S MENTAL HEALTH SYSTEM

The foundational component of the Partnerships for Recovery initiative is the Mental Health Transformation Project (MHTP), funded through the SAMHSA Transformation Grant. Using the six goals outlined in the President's New Freedom Commission final report as a blueprint, the Governor's MHTP proposal was designed to transform the state's mental health system to a more responsive network of integrated, effective services. The successful proposal was submitted in June of 2005, and Washington State received a Notice of Grant Award in October 2005.

A condition for all the states receiving SAMHSA Mental Health Transformation Grants is that the Governor's Office in each of these seven states directs Transformation activities through a high-level Transformation Work Group. Washington State's Governor Gregoire is leading the *Partnerships for Recovery and Resiliency Initiative* with the full support and participation of the director of every department and division serving people with mental illness in the state of Washington. With consumers and family members as equal partners, the partnership has launched a deep transformation effort to achieve the goals of the President's New Freedom Commission for all people in the state of Washington.

The Transformation Process relies on broad

The Transformation effort relies on the participation of consumers and families, including their

participation from the entire mental health community, particularly consumers and family members

membership in Transformation Work Group (TWG), in outreach, education and training, policy formation, evaluation and public education campaigns. This approach of bringing consumers and families into the transformation effort as full partners ensures the transformation process will result in a comprehensive, culturally competent, fully integrated, consumer- and family-centered system committed to continuous improvement.

Washington's MHTP has been built on the foundation of the President's New Freedom Commission Report. However, what is emerging in Washington State is unique to the needs of the consumers and families of Washington. The MHTP is building the infrastructure to support an on-going process of planning, action, learning and innovation that will result in measurable improvements in the lives of both young and old throughout the State.

The Transformation Work Group

Governor Gregoire appointed the Transformation Work Group (TWG) to carry out the work of the MHTP. The director of every state agency and division serving people with mental illness in the state of Washington is an active participant in the project. With consumers and family members as equal partners, the TWG has launched a deep transformation effort to achieve the goals of the transformation grant. The TWG is assisted in its work by 11 project staff, and a variety of supporting committees.

The senior executive-level TWG provides on-going oversight and direction to the Transformation Project, and is charged with implementing the transformation effort. The 32-member TWG includes state agency directors, adult and youth consumers, and family members and representatives of local government and private sector mental health providers and advocates.

The TWG was charged with developing the Comprehensive Mental Health Plan (CMHP). To accomplish this, the TWG established an ambitious Year 1 work plan. (Exhibit 1 provides a graphic overview of the TWG's Transformation Process during Year 1 of the MHTP.) The TWG first identified seven areas for analysis, focusing on target populations.

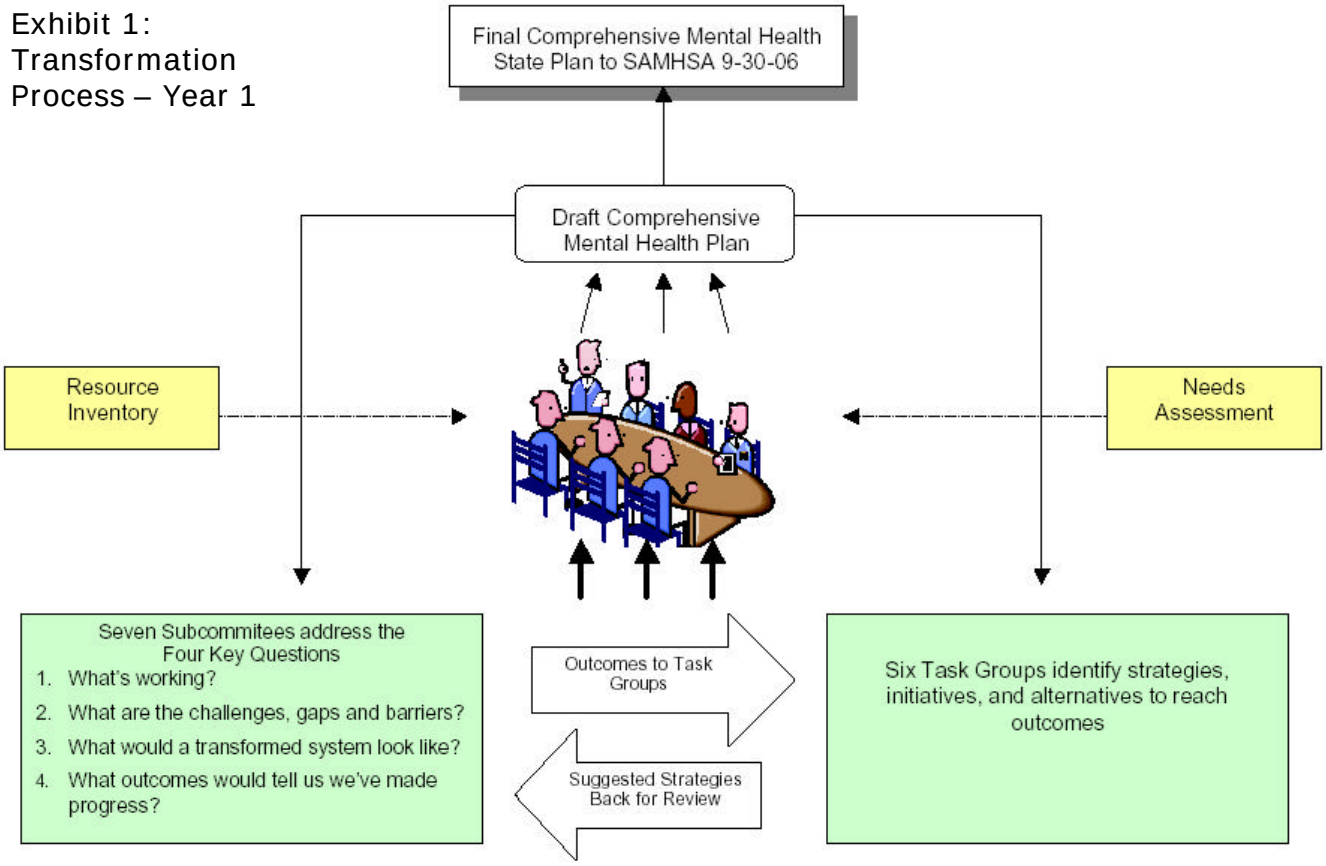
1. Children/Youth and Parents/Families
2. Adult Consumers and Families
3. Older Adult Consumers and Families
4. Youth Transitioning into Adulthood
5. Homeless Population
6. Criminal Justice-Juveniles and Adults
7. Co-Occurring Disorders (Dual Diagnoses)

Consumers, Family Members, Agency Staff, Public and Private Service Providers have all participated in creating the vision of a transformed mental health system

Subcommittees were established to examine each of these areas and to define desired outcomes for each population set. To ensure the subcommittees remained focused on envisioning a consumer-driven system, each subcommittee was comprised of at least 51% consumers and/or family members. Each subcommittee took public testimony from interested parties around the state to seek feedback on ***what a transformed system should look like.*** Testimony came in a variety of formats, including public forums, surveys, informal emails, etc***.*** Respondents were asked to address the following four questions:

- Within Washington State, and for all mental health services, public or private, what is working well when addressing the needs of the Subcommittee's target population?
- Within Washington State, and for all mental health services, public or private, what is NOT working, creates barriers or fails to provide quality service and support when addressing the needs of the subcommittee's target population?
- Related to the subcommittee target population, what would a "transformed" mental health system look like?
- What outcomes would indicate that the changes in the mental health service systems are creating improved results for consumers?

Exhibit 1: Transformation Process – Year 1



Transformation Process in Year One of Implementation

Relationship of Subcommittees to Task Groups, TWG and the Comprehensive State Plan

Each subcommittee met at least three times around the state, holding public forums and taking testimony from consumers, their families, local providers and other stakeholders. In total, over 40 public input sessions and RSN-sponsored listening sessions were held over a 55-day period. These forums focused on the four questions listed above and the feedback was compelling. Transcripts from each of these input sessions can be found at the MHTP website (www.mhtransformation.wa.gov). The public input and listening sessions produced over 6,000 pages of transcripts. Researchers and analysts from the University of Washington conducted a thematic analysis on these documents. Summaries of those analyses are provided in Appendix 1.

Following the public input sessions, the subcommittees had the difficult tasks of distilling the wealth of information received, and identifying the top three to five critical outcomes within their subject area. In total, the subcommittees recommended 27 key outcomes for further exploration and development. These recommended outcomes are described in more detail in the following sections, grouped by the relevant Presidential Goal. The subcommittees' recommended outcomes were adopted by the TWG without modification.

PRIORITY OUTCOMES:

Criminal Justice

1. Decreased number of people with mental illness from entering into the criminal justice system.
2. Increased access to mental health and substance abuse services for those within the criminal justice system.
3. Decreased number of people with mental health illness re-entering the criminal justice system.

Co-Occurring Disorders

4. Consumers will have access to appropriate, quality treatment regardless of barriers and/or resources.
   - Services will be specific to the individual's needs.
   - There will be access to sufficient treatment providers who trained and retained.
5. Affected parties are informed, educated and knowledgeable about co-occurring disorders and the recovery culture, principles and philosophy.
   - Peer-to-peer support is available to all who want it.
   - Communication between and among the parties is critical to making this successful.
   - Law enforcement officers receive crisis intervention training to deal with co-occurring disorders.
6. Increased system collaboration and service integration is prevalent across all allied systems and services.
   - Reduction in silos across system boundaries
   - Increased holistic services
   - Increased cross-system treatment
7. Service delivery is consumer driven and recovery focused.

   There are options available outside of the current standard options such as homeopathic services.

Youth in Transition

8. Consumers and family members have choices, utilize self-directed care and are sponsors, mentors and guides (i.e. peer-to-peer support). Services and supports are tailored to their cultural, community and individual needs.
9. a) Seamless, holistic care to include mental health, physical health and dental integrated for all youth 13 – 24 that provides for access on demand and includes early identification, intervention, housing, benefits and transition to adulthood. Systems use practices that have been known to work.
9. b) Reduce stigma through on-going education and training about recovery and resiliency developed by consumers and family members.
10. Consistent access to quality services and

supports available regardless of location or funding sources.

11. Consistent access to quality services and supports available regardless of location or funding sources.

Adult Consumers and Families

12. Funding is attached to the consumer, allowing the consumer, with the assistance of a recovery coach, to select and self-direct services they believe will assist them in their recovery process and to purchase these services directly. All consumers will have a choice of services in which they can become engaged that include at a minimum:
    - Consumer-run services of various types
    - Individual therapy with a qualified therapist
    - Clubhouse services
    - Case management services
13. State regulations will be modified to allow consumer-run entities that are independent of the community mental health agencies to provide Medicaid-eligible consumer-run services.
    - Within five years, these services will represent 25% of all mental health services in Washington State, and
    - Within five years, 20% of adult consumers are employed as service providers in traditional mental health agencies and/or in the new consumer-run entities.
14. Everyone working in the mental health system is trained and certified in psychiatric rehabilitation through college programs specially designed to provide such training. All recipients of services are also trained in psychiatric rehabilitation.
15. The ombuds system is independent of the mental health system (MHD, RSNs, and provider agencies).
16. Consumers have access to evidence-based vocational rehabilitation services on demand that include high quality supported employment based on national standards. These programs work collaboratively with DVR to ensure employment for as many consumers as possible.

Older Adult Consumers

17. Older Adults will have improved and consistent access to appropriate mental health services, including outreach to place of residence.
18. Mental Health services for Older Adults will be provided and funded in an integrated holistic model of care including mental health, medical, substance abuse, social services and spiritual.
19. There will be an increased number of service providing individuals with professional experience in mental health and aging.
20. Appropriate mental health services for older adults are coordinated across all systems of care at state, regional and local levels.

Homeless

21. Housing will be available immediately upon need for individuals/families.
22. Services are available immediately, regardless of the financial or categorical status of the individual or family, while other benefits and services are being applied for.
23. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).

Children/Youth and Parents/Families

24. Greater availability of state-only funds.

    This would require a decrease in requirements around State-only funds and an increase in the flexible use of these funds. With that in place we would purchase with:

    – State-only funds for parent organizations, mentorships.

    – State-only funds to serve those who are not in the country legally, non-Medicaid children/youth and families.

    – State-only funds to serve working poor and people who have exhausted their insurance benefits.

25. Youth and family support (this includes any caregiver family including foster, adoptive and kinship families).

    – Increased parent and youth organizations, support groups, peer support and parent partners. Partnership involvement needs to be

visible at all levels where youth and parents are always at the table; this includes parent/youth participation in client driven/directed services.

26. Training and Education.

- This is inclusive of partnerships that would include parents/youth and professionals as trainers, who are responsive to cultural diversity, which goes beyond linguistics and ethnicity.
- Trainings would include a basic level of information regarding mental illness and strategies and interventions about how to deal with issues as they surface.
- Trainings would be targeted towards teachers, in an effort to help stabilize children and youth experiencing mental illness in the school environment. Trainings for parents, kinship caregivers, adoptive parents and foster parents would include behavioral intervention and crisis management skills. Other professionals also need to be trained and all trainings need to start early and include Birth to Three issues.

27. A system that is more proactive than reactive.

Serve the WHOLE family with a full continuum of community based services, starting with prevention and early intervention. Services would be available for parents/caregivers when the child is in an out of home placement even though the parent may have lost their Medicaid coupon. There would be a wide range of available individualized services in the community that are supportive to families so they can keep their child at home and not give up custody so their child can get services.

Additional services in the continuum would include respite, wraparound services, day treatment, and evidenced based programs. It would build on family strengths and resiliencies and support parent partnering, and is well coordinated (seamless) among the systems. Services would be available to be delivered in the family home or other community locations or

family preferences.

- Revisit the Access to Care standards and open the door to access.
- Decrease in families seeking voluntary placement agreements.
- Increase in mental health treatment and community supports for parents/caregivers and their children to keep children in their homes or successfully return children to home after an out of home placement (Juvenile Rehabilitation Administration, Children's Long-Term Inpatient Program, Children's Administration are a few examples where children may be returning from)
- Increase in community services and supports for families. This includes respite, wraparound services, day treatment and evidenced based practices.

Subject Matter Experts have identified recommended strategies for achieving these outcomes

In addition to the seven subcommittees, task groups of subject area experts began meeting in April 2006 to prepare recommended strategies for transformation. The TWG directed the task groups to identify potential strategies and approaches that would achieve the outcomes recommended by the subcommittees and approved by the TWG.

The task groups were charged with drawing on the most cutting edge research and practices to develop specific strategies for achieving the outcomes identified by the subcommittees. Where the subcommittees were focused by population groups, the task groups were defined by functional area:

1. Evidence-Based, Promising and Emerging Practices
2. Information Technology (IT) Systems
3. Fiscal Systems
4. Cultural Competence
5. Social Marketing
6. Evaluation

The task groups met intensively over a two-month period to develop principles and strategies for achieving the transformation outcomes established

by the TWG subcommittees earlier in the year. In considering the recommendations of the task groups, the TWG focused on the overarching principles and approaches, rather than focusing on specific individual strategies. This reflects an understanding among the TWG members that implementation activities will undoubtedly reveal unanticipated challenges, barriers, or sequencing issues. Additional strategies may need to be developed if gaps emerge, and limitations discovered during planning and implementation may require reprioritization or elimination of some strategies.

In Year 2 of the MHTP, the TWG will support efforts to translate these principles, strategies and desired outcomes into concrete action items. The TWG will provide support in the form of training, education and facilitation to ensure these transformative approaches are brought to fruition at all levels, from government policy and procedure, to clinical practice. MHTP funds cannot be used to provide services. They will be used to develop the transformation infrastructure necessary to pursue the 27 Recommendations of the subcommittees.

State Agency Strategic Plans Provide a Rich Environment to Begin the Implementation of the TWG's Transformation agenda.

Now that the transformation framework has been developed through the work of the subcommittees, task groups, and articulated within this CMHP, the TWG will shift its focus to planning and implementation. The TWG in itself cannot make this vision a reality. Instead, the TWG will encourage its implementation through education, training, facilitation and creating strategic partnerships with state agencies, educational institutions, and community organizations.

Transformation has already begun

Translating the results of the TWG's Year 1 efforts into on-the-ground changes has already begun. At the Governor's direction, Washington State agencies have completed an extensive strategic planning process. Agencies responsible for implementing mental health services included a number of strategies for implementing transformative services. Many of the agency strategic plans are being implemented in conjunction with and as a complement to the formal outcomes and strategies defined by the MHTP subcommittees and task groups. These strategic plans set forth the agencies' strategic goals for the coming years and, more

importantly, the objectives and specific strategies for achieving those goals. MHTP staff members have worked closely with agency staff to identify transformative strategies in those plans. Once identified, the MHTP resources can be applied to those areas that fit within the transformation framework articulated in this CMHP. Excerpts from the various strategic plans are incorporated in Washington's response to each Presidential Goal outlined in Chapter 1.

The Comprehensive Resource Inventory and Needs Assessment is Complete

The MHTP Evaluation Team has completed an exhaustive needs assessment and inventory of resources devoted to serving seriously mentally ill adults and seriously emotionally disturbed children and youth. This effort has deepened the initial resource inventory that was included with the grant proposal.

Information gathered from the inventory process will ultimately be assembled into a statewide mental health resource inventory database that will be updated annually. The annual summary will be provided to the Governor, the legislature and the Mental Health Planning and Advisory Council. The inventory will become more refined and useful over time and will become an integral element in the state budgetary and planning process.

The Needs Assessment component of this effort will be used to help shape the Washington State transformation effort on into the future. The results of this assessment draw a compelling picture about the need for transformative efforts to recreate a mental health system and environment that puts the consumer and families at the center. A more detailed discussion of the Resource Inventory and Needs Assessment is included in Chapter 5 and the full report is included as Appendix 2.

CHAPTER 1:

WASHINGTON'S TRANSFORMATION IN ACTION

CHAPTER OVERVIEW

The six goals outlined in the President's New Freedom Commission final report provide a framework for transforming Washington's mental health system. This chapter describes Washington's approach to achieving the President's goals. In addition, the Washington Transformation Work Group has added two new goals specific to Washington State relating to employment and Housing. These are addressed here as well.

For each goal, we provide the following:

- Priority outcomes identified by the TWG subcommittees,
- Strategies for implementing the priority outcomes,
- Agency partner strategic plans,
- Other MHTP transformation activities, and
- Gaps and next steps associated with the goal.

Taken together, these responses act as a roadmap, describing Washington's route to transformation. Specific implementation strategies and timelines will be developed in Year 2.

Consumers and their family members have been active partners in developing every recommendation and initiative. A detailed discussion about the process for involving consumers and their families in the initial outcome and strategy identification process was included in the Introduction.

Subcommittees identified 27 desired outcomes for a transformed mental health system

The previous chapter provides an overview of the process used by the TWG to develop the substance in this CMHP. To briefly recap:

Seven subcommittees were appointed by the TWG to examine the strengths and weaknesses of the mental health system on specific population groups (children, youth, adults, older adults, the homeless, individuals with co-occurring disorders, and those involved in the criminal justice system). From their outreach and public input sessions, the subcommittees identified 27 priority outcomes for a transformed system.

Task Groups developed specific strategies for achieving those outcomes

Task groups then defined specific strategies for achieving those outcomes. Task groups were structured around functional areas (fiscal systems, information technology, evidence based, promising and emerging practices, cultural competence, evaluation and social marketing).

Several over-arching strategies and goals are inherent in the task group work products

In some cases, task groups were not able to be specific about strategies until adddtional detail became available that was not planned to be available until years 2-5 of the transformation grant activities. In lieu of, or in addition to, the specific strategies the Fiscal Systems, Information Systems and the Cultural Competence Task Groups defined principles that will guide their activities in the coming years. These principles are contained in Appendix 3.

Agency partners are actively involved in transformation

Many transformative activities are currently underway and documented in each of the agency partner's strategic plans. A summary of these plans as they relate to the goals has been included in this chapter. However, agency partners have told the Transformation Project staff that there are many activities they are involved with that are not listed in their strategic plans. The project staff plans to inventory these strategies for inclusion in next year's plan.

In addition, state agencies are currently developing budget requests and proposed legislative packages for the 2007-2009 budget period. By September, the agencies will submit these requests to the Governor's Office. Because of the need to finalize the Comprehensive Mental Health Plan by early September, these budget/legislative requests will not be included in the first year's plans. Once we know what is incorporated into the Governor's legislative package, and which items are supported by the Legislature, a more accurate gap analysis between the community recommendations and agency activities can be conducted. Once that is done, the state will have a better idea about where to focus its resources to address community priorities.

SECTION 1:

Federal New Freedom Commission Goal #1

Americans Understand that Mental Health is Essential to Overall Health.

FEDERAL RECOMMENDATIONS

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

1.2 Address mental health with the same urgency as physical health.

Reducing the devastating effects of stigma associated with mental illness has become a high priority in Washington State

Results from Washington's Resource Inventory and Needs Assessment highlight the need for efforts designed to educate the general public and reduce the effects of stigma:

- Over half of the consumers surveyed (53%) felt stigmatized due to their mental illness,
- Half of the responding consumers (50%) believed they had been discriminated against because of their mental illness, and
- Nearly two-thirds of the respondents (62%) believe that people ignore them or take them less seriously because they have a mental illness (See Appendix 2 for the detailed report).

To combat these disturbing results, the Transformation team is partnering with the Department of Health and other agencies to initiate a social marketing campaign. This campaign is designed to reduce the stigma of mental illness, increase awareness of mental health as an essential part of health, and increase support for mentally ill individuals in the community and workplace, and is being undertaken as part of the CMHP. This initiative is described in more detail below.

Subcommittee Recommended Outcome

The MHTP Subcommittees defined the following outcome to address Federal Goal #1. A complete list of strategies and outcomes is included in Appendix 3.

Youth in Transition Subcommittee	1. Reduce stigma through on-going education and training about recovery and resiliency developed by consumers and family members.
Task Group Recommended Strategies	The following strategies were defined by the MHTP Task Groups in response to Presidential Goal #1.
Evidence-Based/ Promising/Emerging Practices Task Group	1. Use social marketing campaigns aimed at reducing stigma. For example, *Speak Up When You're Down* is a social marketing campaign around normalizing post-partum depression responses and reducing stigma and is already funded by the Washington State Legislature. 2. Integrate center for health, mental health and life skills support (examples school health clinics).
Agency and Partner Strategic Directions	The following objectives and supporting activities and measures related to Federal Goal #1 are defined in state agency strategic plans recently submitted to Governor Gregoire.
DSHS, Aging and Disability Services Administration (ADSA)	ADSA will continue to participate in the Co-occurring Disorders Interagency Committee with the Divisions of Alcohol and Substance Abuse and Mental Health, and co-sponsor the annual co-occurring disorders conference.
DSHS, Division of Vocational Rehabilitation (DVR)	The DVR partners with the State Rehabilitation Council, State Independent Living Council, Client Assistance Program and others in the disability community to learn and respond to identified needs and issues.
DSHS, Division of Alcohol and Substance Abuse (DASA)	Working with other state agencies, consumers, providers and local government, DASA co-sponsors an annual conference on co-occurring mental illness and chemical dependency. In addition, multiple state agencies are involved in a planning group, the Co-occurring Disorders Interagency Committee (CODIAC), which conducts cross-system planning as well as an annual conference.
DSHS, Health and Recovery Services Administration (HRSA)	The HRSA emphasizes preventive health measures and healthy lifestyle choices. Key elements of the HRSA strategic plan include: • Retain a preventive focus in Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Access to Baby and Child Dentistry, First Steps – families with children, and family planning.

- Sustain existing state-subsidized health-care coverage for low and moderate-income children.
- Distribute evidence-based information on prevention and healthy lifestyles for clients through many different community venues, among them the Department of Health, public schools, public health districts, community clinics and libraries statewide.
- Continue efforts on reducing unintended pregnancy.
- Expand Disease Management capacity to recognize positive effects of care management on serious disease complexes.

DSHS, Mental Health Division (MHD)

The MHD will actively promote recovery, resiliency and the reduction of stigma for persons experiencing mental illness across the life span. Specific strategies will:

- Provide outreach and showcase of consumers' skills and abilities as a means of stigma reduction.
- Provide opportunities to allow consumers to share their stories of recovery with others.
- Develop advertisement campaigns promoting recovery and community support of persons in recovery from mental illness; consumers will be involved in the design and implementation of the campaign.
- Support working with counties and agencies to promote recovery and resilience and to reduce stigma regarding the mental health system.
- Create a recovery manual in collaboration with the Washington Institute (similar to the domestic violence manual) and distribute it throughout the mental health delivery system as a whole, including the Criminal Justice System.
- Develop triage units and create additional mental health courts wherein persons with mental illness, when possible, will be diverted from the criminal justice system and will be assessed for treatment at the onset of involvement with the state to intervene and prevent incarceration.

MHD will require that all persons experiencing mental health issues be treated with respect, understanding and compassion by:

- Developing mission statements for persons working with the MHD and contract agents that incorporate the values of respect, understanding and compassion as fundamental in treatment of persons experiencing mental illness.
- Working with counties and agencies to promote these values.
- Adopting philosophies such as the Rochester New York Emotionally Disturbed Persons Response Team, which makes every effort to preserve the dignity of each individual encountered who is emotionally disturbed or experiencing mental illness.
- Providing training for clinical providers to adhere to these minimum standards of treatment of respect, understanding and compassion.

Department of Health (DOH)

The state DOH is responsible for keeping Washington's citizens healthy and safe by working across agencies and with local partners. DOH's mission is to protect and improve the health of people in Washington State – mental health is part of the definition of health.

Department of Veterans Affairs (WDVA)

In our effort to care for vulnerable adults in our veteran homes, as well as within our Homeless Veteran and Trauma Treatment Programs, we stress the holistic nature of wellness, including the role of mental health, healthy choices, diet, exercise, smoking cessation, weight and stress management.

Transformation Grant Activities

Washington's Comprehensive Mental Health Plan addresses this state's commitment to overcoming these barriers by educating the general public about mental illness, educating consumers and their families about excellent care and service options, reducing obstacles to achieving needed recovery options, and increasing the general public's understanding that mental health is only one aspect of a person's overall health and should be understood and managed on a comparable level.

Highlighted below are a number of transformative strategies that have already begun with the support of the Mental Health Transformation Grant through its partners.

Reducing Stigma Using Social Marketing:

A Project Framework and Research Design

Washington's Social Marketing initiative will join other campaigns across the country working to change public attitudes and behavior toward mental health. This project is working to:

- Eliminate stigma and the barriers it creates in the work setting, at home, within the healthcare system and in the community, and
- Increase the understanding that people with mental illness can and do recover and live productive lives.

Who Is Working On This?

Health educators at the Washington State Department of Health are facilitating the social marketing aspect of the grant. They are reviewing the current literature on mental health issues as well as the transcripts and reports from the public listening sessions and subcommittees to ensure that consumer and family perspectives are reflected in the marketing plan design.

They are also convening a Social Marketing Task Group representing business, provider, consumer, family, marketing and public policy perspectives. The task group will help guide audience research decisions and help formulate the recommendations for social marketing efforts during the course of the grant funding.

The process for developing the social marketing implementation plan took place in the Spring and Summer of 2006. The work was accomplished in four phases:

Initial Planning:

- Collect available research, data and best practices
- Determine research needs and resources
- Review target audiences, segments within each audience, and characteristics that influence or determine their behavior
- Select potential target audiences and behaviors that this project will address
- Set initial goals and objectives

Formative Research:

- Conduct focus groups and interviews
- Obtain reactions to project messages, goals, objectives and potential strategies

- Test existing campaigns
- Determine baseline knowledge, attitudes and behaviors

Strategy Formation:

- Review research findings and recommendations
- Select target audiences
- Develop program strategies

Program Development:

- Finalize social marketing strategies
- Identify and mobilize additional partners to assist with dissemination and implementation

What has been Accomplished To Date?

The MHTP Social Marketing Task Group focused its initial efforts on three key groups:

- Providers of publicly funded mental health services;
- Policy makers (specifically, the Mental Health Transformation Workgroup, local elected officials, and the Joint Legislative & Executive Mental Health Task Force); and
- Consumers.

Mental health providers and policy makers are necessary participants in eliminating stigma as they are examples of what the literature refers to as "key power groups" – that is, groups that have the power to significantly affect the lives of individuals with mental illness, either positively or negatively. Involving consumers in this effort was also considered important, as the literature indicates that contact with people with mental illness is one of three effective stigma reduction techniques.

Employers form a fourth key group. Employers have significant influence on social acceptance and reducing stigma associated with mental illness through hiring practices. Employers will be included in future phases of the social marketing initiative.

The Social Marketing Task Group has focused on identifying key audiences and messages in Year 1

In the first year, formative research has been conducted with providers, policy makers and consumers using a combination of key informant interviews and focus groups. The intended outcome of this research was to determine which group(s) has the biggest potential impact on the elimination of stigma associated with mental illness, the most readiness to act, and what the effective strategies are to motivate action.

The Social Marketing Task Group reviewed research findings and provided recommendations to the TWG regarding priority audiences, messages and strategies for the duration of the Mental Health Transformation Project.

The desired actions, or behavioral outcomes, for each target audience were identified and further refined by a review of the current literature.

Future work will focus on implementation strategies

In subsequent grant years, results of the audience research will be used to develop strategies for implementation. Potential strategies include educational activities that promote understanding that mental illness is treatable, that people with mental illness are people first and should not be defined by their illness, and that recovery is the process of developing a positive and meaningful life separate from one's psychiatric condition.

Strategies will also likely take advantage of the best practice of "contact," shown to have a deep and lasting effect on reducing stigma and breaking down stereotypes. Programs that connect consumers engaged in recovery with key power groups in the community can increase understanding about mental illness as a treatable, manageable condition and increase hope for recovery for consumers and their families.

Washington is working to establish parity in its health delivery system

— Washington's Mental Health Parity Act

Washington has defined a comprehensive strategy to address the financing challenges posed by the current system. For the past several legislative sessions, mental health advocates pressed diligently for the passage of legislation that would require private insurers to cover mental health services comparable to their coverage of other medical and surgical services. During the 2005 regular legislative session, the state's first Mental Health Parity Act [SHB 1154, Chapter 6, Laws of 2005] was passed and signed into law by Governor Gregoire.

The law applies to commercial health plans regulated by the Washington State Insurance Commissioner and requires employers with more than 50 employees to provide mental health care coverage. All state employee health plans offered by the Public Employees Benefits Board and Washington State Basic Health are also included. While the Mental Health Parity Act does not apply to all employer provided health care plans, the fact remains that

	2005 was a landmark year for legislation related to mental health issues, and the four-year phase-in of the parity legislation will benefit many citizens of Washington affected by mental illness.
Gap Analysis	The community process has focused most of its attention on stigma reduction and suicide prevention. State agencies have identified a variety of activities related to stigma reduction and these activities will be pursued in Year 2 along with the Social Marketing Campaign. At least one state agency has a suicide prevention initiative and one of our research partners (University of Washington) also has suicide prevention initiatives. The issue of mental health being treated with the same urgency as physical health was not well-defined in our community process, nor was it addressed in agency strategic plans. There may be additional strategies agencies are pursuing that are not in their strategic plans or that are part of their 2007-2009 proposed budget/legislative packages. These packages will not be available until September.
Next Steps – Year 2-5	The Transformation Grant will partner with the TWG and research partners regarding suicide prevention initiatives in Year 2. Washington is pressing for a link between physical and mental health in State Policy and will also pursue treating mental health with the same urgency as physical health as part of a Year 2 priority.

SECTION 2:

Federal New Freedom Commission Goal #2

Mental Health Care is Consumer and Family Driven.

FEDERAL RECOMMENDATIONS

2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
2.3 Align relevant Federal programs to improve access and accountability for mental health services.
2.4 Create a Comprehensive State Mental Health Plan.
2.5 Protect and enhance the rights of people with mental illnesses.

Consumers in Washington voiced concerns similar to those raised at the federal level

During MHTP-sponsored statewide public input sessions held earlier this year, consumers and family members voiced concerns about Washington's current mental health delivery system that mirror concerns raised in the President's New Freedom Commission report.

- Choices are limited for service offerings that are flexible, customizable to the consumers' needs and accessible in all parts of the state.
- Frequently, the only services available (although not always when they were needed) include more traditional medication management and case management services.
- The system, through its policies and financing decisions, drives treatment decisions instead of the consumer and family members making decisions based on their needs.

Current policies and practices perpetuate the perception that the mental health consumer is "ill" and do not support the notions of recovery and resiliency. As a result, services that would maintain and support the integration of a consumer into the community, such as housing and employment opportunities, are not readily available.

Subcommittee Recommended Outcomes

In response to the New Freedom Commission recommendations, the following strategies were recommended by the subcommittees to address Presidential Goal #2.

A complete list of strategies and outcomes is included in Appendix 3.

Co-Occurring Disorders Subcommittee

1. Service Delivery is consumer driven and recovery focused.
    - There are options available outside of the current standard options such as homeopathic services.

Youth in Transition Subcommittee

1. Consumers and family members have choices, utilize self-directed care and are sponsors, mentors and guides (i.e. peer-to-peer support). Services and supports are tailored to their cultural, community and individual needs.

Adult Consumers and Families Subcommittee

2. Funding is attached to the consumer, allowing the consumer, with the assistance of a recovery coach, to select and self-direct services they believe will assist them in their recovery process and to purchase these services directly. All consumers have a choice of services in which they can become engaged that include at a minimum:
    a. Consumer-run services of various types,
    b. Individual therapy with a qualified therapist,
    c. Clubhouse services, and
    d. Case management services.
3. State regulations will be modified to allow consumer-run entities that are independent of the community mental health agencies to provide Medicaid-eligible consumer-run services.
    - Within five years, these services will represent 25% of all mental health services in Washington State, and
    - Within five years, 20% of adult consumers are employed as service providers in traditional mental health agencies and/or in the new consumer-run entities.

Children/Youth & Parents/Families Subcommittee

1. Youth and family support (this includes any caregiver family including foster, adoptive and kinship families).
    - Increased parent and youth organizations, support groups, peer support and parent partners. Partnership involvement needs to be visible at all levels where youth and parents are always at the table; this includes parent/youth participation in client driven/directed services.

Task Group Recommended Strategies

The following strategies were defined by the MHTP Task Groups in response to Presidential Goal #2.

Fiscal Task Group

1. Consumers and families should have greater responsibility/opportunity to direct services and expenditures.

Cultural Competency Task Group

1. Identify, document, validate, implement, and support promising programs and practices that currently exist in the community.
2. Identify, implement, validate and support traditional medicines, alternative medicines and cultural traditional approaches that currently exist in the community.
3. Support efforts to document and validate emerging programs and practices and disseminate promising programs and practices statewide.
4. Provide technical assistance and support to mainstream and specialty mental health provider agencies to promote increased capacity to serve special populations, resulting in development of cultural competence teams that will provide ongoing technical assistance.
    - Provide financial and other incentives for achievement of cultural competence as demonstrated through comparable access and results from service across diverse population groups.

Evidence-Based/ Promising/Emerging Practices Task Group

1. Mobilize curricula (examples: MOVE, TARGET-T).
2. Use Youth Empowerment and Engagement/life skills development curricula that includes mental health education component (examples include MOVE, TARGET-T).
3. Identify and mobilize mentors, navigators, peer advocates and other supports for family members, youth and young adults.
4. Implement a consistent statewide mechanism to ensure that the philosophy/value of family and youth involvement is taught in certification, university, and other training programs.
5. Develop a mechanism to ensure funds are available to support family and youth participation in the planning, implementation, evaluation, and policy of programs and practices (i.e., stipends, transportation, childcare, etc.).
6. Fund the development of a minimum of one independent consumer-run drop-in/resource center in each RSN.
    - These resource centers will serve as each area's umbrella organization, where trained peer counselors will assist individuals in the recovery process, including goal-setting, warmlines, developing mutual self-help groups, teaching problem-solving skills, providing vocational assistance, and developing plans for symptom management using the Wellness Recovery Action Plan (WRAP) model.
7. Fund the development of a minimum of two recovery education centers, to be run by consumers; one in Eastern Washington and one in Western Washington.
    - These centers will serve as the state's technical assistance centers offering technical assistance around consumer run services and principles of recovery.
8. Fund the development of a minimum of one clubhouse model psychiatric rehabilitation program in each RSN based on the Fountain House model.

- Free-standing clubhouse programs should be allowed to become one version of a "consumer-run entity."
- The definition of a clubhouse should be the definition of a clubhouse program as articulated by the International Center for Clubhouse Development (ICCD).
- Clubhouse programs in Washington should be required to be certified by the ICCD.
- Clubhouses should be funded in such a manner that makes it possible for the program to operate in complete fidelity to an ICCD defined clubhouse.
- Clubhouse funding must be flexible enough to ensure that clubhouse services are consumer-directed, and that the clubhouse's overarching focus is vocational rehabilitation and job and educational placement.
- Clubhouses are not clinical programs – admission criteria and service planning is not based on diagnosis, level of functioning or medical necessity. Clubhouses are adjunct to clinical services and focus on people's strengths.

9. Expand Personal Assistance Services (PAS) for people with psychiatric disabilities. PAS is a method which already has a long and successful track record for serving people with disabilities in a self-determined manner, and for which Medicaid funding is already available.
10. Provide support for consumer-owned and operated businesses.
11. Use peer support models such as dual recovery and double trouble.
12. Ensure that promising family-centered processes and support services voiced as needs by communities that are not focal treatments (e.g., Youth and Family Supports/Parent Partners, including parent organizations, peer support, support organizations, parent partners, Respite Care services, Mentoring, the Wraparound process, Day treatment programs) are supported and included as options for communities.

13. Designate funding specifically to create/support/ maintain Family and Youth Organizations and support programs.

14. Review statutory & administrative constraints to funding/reimbursement of parent/ youth partners and minimize barriers

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to Federal Goal #2 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Division of Alcohol and Substance Abuse (DASA)

The DASA oversees a Citizen's Advisory Council in which two-thirds of its members are required to be consumers and/or family members, some of whom have co-occurring mental health and chemical dependency issues. The division also funds the Family Resources Institute that focuses on services to families with fetal alcohol syndrome. The institute provides support and training to family members.

In addition, DASA administers a SAMHSA "Access to Recovery" Grant that allows consumers to use a voucher system to choose the services they need, including mental health.

DSHS, Health and Recovery Services Administration (HRSA)

The HRSA plans to integrate service delivery systems by putting clients at the center of their health care and recognizing that timely attention to non-medical needs can avoid greater medical needs and costs in the future. In addition, the HRSA plans to emphasize health education, prevention and cultural competence so that clients are better equipped to pass over barriers that now limit access to primary care.

DSHS, Mental Health Division (MHD)

With the passage of E2SHB 1290 in 2005, the legislature strengthened the public mental health system so that people experiencing mental illness receive services focused on resilience and recovery. The bill was written to ensure that adults and children with mental illness, their families, and their advocates are intimately involved in designing mental health services that reduce unnecessary hospitalization and incarceration. The legislation is a move toward a statewide system that supports consumers to be able to live, work, learn, and participate fully in their communities. E2SHB 1290 aims for consumers to have the community and personal qualities that empower them to rebound from trauma, adversity, tragedy or other stresses and can lead productive lives.

MHPAC brings a strong consumer voice to policy and practice development

The Washington State Mental Health Planning Advisory Council (MHPAC), mandated by state and federal Law, reviews, monitors and evaluates the MHD's policies, plans and budgets. MHPAC also makes recommendations to the division about ways to strengthen the link between government decisions and consumer, family and advocate's needs and concerns. MHPAC's subcommittees include groups dedicated to the needs and concerns of children, elders, ethnic minorities, and gender preference and sexual minorities. MHPAC's membership includes a strong consumer voice, with 51% of its members representing consumers, family members and advocates. Other MHPAC members represent RSNs, service providers, and state agencies.

MHPAC's new goals are adopted from the six goals found in the New Freedom Commission's final report, Achieving the Promise: Transforming Mental Health Care in America.

- Consumers and family members will direct their own recovery and resilience planning, through the following activities:
    - — Implement a resilience and/or recovery model whereby the consumer and their community of family or caregivers determine needs for their individual recovery and resilience plan.
    - — Develop an education and training program to assist care providers (including primary care physicians) and consumers in understanding resilience and recovery to ensure consistent use of these words and meanings.
- Expand the information on Social Security (SSDI, SSI), Ticket to Work, Medicaid buy-in, and other employment opportunities for adult consumers.
- Require the integral involvement of consumers in the development of their recovery and resilience process/plans.
- Request revisions to the Revised Code of Washington (RCW) Chapters 71.24, 71.34 and 71.05 to reflect current program realities and to clearly state the rights of consumers.

- Provide training to consumers in the development of Wellness Recovery Action Planning (WRAP). Training will be offered to consumers at least annually.
- Expand information on and promote accessibility to the Social Security Administration, Medicare and other community services that promote/support older adults in maintaining optimum function and meaningful activities.
- Expand peer counseling to support consumers across the life span.
- Develop and implement concepts and programs that prioritize goals and outcomes that foster autonomy rather than maintenance and codependency.

The MHD will involve consumers, their families, caregivers, and advocates in all program design and planning of the recovery and resiliency process.

- Increase the role of consumers across the life span and families in quality management activities within MHD, state hospitals, RSNs, Community Mental Health Centers (CMHC), and CLIP via the MHPAC.
- Continue to support the efforts of the Office of Consumer Affairs.
- Showcase examples of consumer/caregiver involvement across the lifespan that demonstrate recovery, resiliency and reduction of stigma.
- Insist on consumer/caregiver presence across the life span on state hospital governing bodies and encourage presence on private hospitals governing boards, particularly where Medicaid money is utilized.
- Provide training to assist consumers and caregivers to find their own voices and tell their own stories.
- Implement a culturally competent service delivery plan.
- Provide mentoring to consumers and families prior to their membership on client/consumer committees and their attendance at stakeholder meetings.

The Mental Health Division will communicate with consumers, and ensure the sustainability of the active involvement of consumers and their advocate caregivers across the life span.

- Utilize the approved consumer self-advocacy training and Executive Order project.
- Promote consumer and caregiver advocacy to assist with legislative proposals and as a tool to influence legislation that promotes recovery and resiliency.
- Develop and train consumers as mental health system advocates in order to expand committee membership expertise.
- MHD staff meets directly with consumers and caregivers through focus groups and/or attendance at meetings.
- MHD supports and receives information from clubhouses to help programs to connect and share a common goal.

The Office of Consumer Affairs (OCA) will develop an addition to the MHD's web page that is specific to adult consumers containing frequently asked questions, definitions, resources, guides, etc. Clubhouses and consumer-run programs will be added as a resource to the MHD's web page.

- Provide training to consumers in the use of the MHD web site.
- Respond to funding and infrastructure changes in the mental health system to sustain the goal of consumer driven services.
- Develop an independent Ombudsman program to support consumer driven services.
- Work with the Joint Legislative and Executive Task Force on Mental Health Services and Financing to implement system change.
- Develop and implement a plan to monitor and evaluate the impact of system changes on consumer care at the provider level.
- Create workgroups to explore the programmatic and financial impact of changing the system structure.

- Examine current law and rule to determine by survey or assessment revisions needed to change the system structure.
- Conduct a risk management review of the system structure change.
- Study the current continuum of care to identify community alternatives to residential, crisis and inpatient capacity needs.

The growing formal network of parents and others working with the MHD has increased awareness by other programs about the benefits of bringing parents, neighbors and friends in as care resources. The mental health system has received requests for technical assistance on the best way to incorporate family and friends into the planning process to deal with children with serious emotional or behavioral needs. Although this network has become more accepted by providers as their community involvement expands, they are not yet universally seen as a resource.

This network believes strongly in their role as a system partner and will continue to be involved as coordination continues to grow. One way this coordination occurs is through the former Parent Council, supported by the MHD. The Parent Council (renamed SAFE-WA -- Statewide Action for Family Empowerment of Washington) received a SAMHSA grant to be the statewide parent/family network, and a major partner in the larger children's system grant submission. SAFE-WA has representation from all of the recognized parent advocacy and support groups in Washington and meets quarterly to bring a united voice to the division's management.

The MHD's Office of Consumer Affairs (OCA) received approval to conduct a two-year, statewide consumer and self-advocacy training program. Initiated in 2004, the ORCA (Outreach for Recovery and Consumer Advocacy) program is designed to improve the division's service delivery to consumer customers, by assisting and supporting consumers statewide. Over the course of the program, OCA staff will:

- Use surveys and focus groups to identify areas requiring improvement;
- Assist consumers in finding services and resolving problems;

- Utilize provider agency consumer advisory groups for consultation and program involvement;
- Educate consumers and collect consumer voice;
- Extend reach and message of state voice;
- Include federal and regional partners in listening to views on consumer issues of interest;
- Provide public speaking and education on mental health and anti-stigma awareness. Promote values of DSHS and HRSA/MH recovery advancements;
- Process and present consumer, client and family voice. Search for success experience and recommendations;
- Retain focus that OCA's overarching mission is to assist leadership to know and value consumer insight in order to help move the system to more recovery treatment options; and
- As part of Director's Office and member of Senior Management Team, provide leadership on system evaluation and feedback; planning input; and policy and design development.

The MHD's OCA also supports the consumer network, which provides direct input to the division.

Throughout the duration of 2006-2011 strategic plan, MHD will meet with stakeholder groups for ongoing input and comment on the division's strategic plan.

DSHS Juvenile Rehabilitation Administration (JRA)

The JRA is responsible for juvenile institutions, group homes, and local parole. JRA also funds county juvenile court and detention services. Their strategic plan focuses their service delivery model continuum on family involvement in the mental health treatment of youthful offenders.

Department of Health (DOH)

The DOH strategic plan includes strategies to assure feedback from citizens. The Office of Maternal Child Health includes individuals and families as partners in shaping decisions, including a full time family consultant. The Health Systems Quality Assurance strategic plan calls for partnerships that promote the public health and customer service.

Department of Veterans Affairs (WDVA)

Since 1984 WDVA has demonstrated a strong interest in creating a specialized mental health counseling program that acts to fill in the rather large gaps that exist between the war veteran with emotional and behavioral issues, and the traditionally identified services of the federal Veterans Administration (VA). Designing the War Trauma/Post-Traumatic Stress Disorder (PTSD) Outpatient Program to be family-oriented from its inception, allowing family members to receive services even before the veteran seeks out assistance. During the current global war on terror, more family members than veterans are receiving services initially. This allows the family members of deployed soldiers, sailors, and airmen, to receive care and support for the family system. As a result, families are better able to manage the pressures of a deployment and as a result are better prepared for the veteran's return.

The PTSD Program has created a network of federal, state, and private organizations and agencies to ensure the wellbeing of children of deployed and war-exposed veterans. The stress of war exposure often acts to regress development progress in children, and to interfere with social and academic progress. Attention to these issues is believed to be essential for not only the readiness of our guard members, but for the protection of our most valuable resource, the children.

In addition, Veteran Homes also are very family-oriented, from admissions through discharge or end of life support and assistance. Social and mental health considerations are always the focus in the treatment plan for residents of the Homes. Special activities tie families together in support of the wellness and care needed for the resident family member, and the continued connections offered by the non-resident family member.

Transformation Grant Activities

As part of the transformation process, Washington State is exploring additional opportunities to expand consumer involvement that is appropriate and sustainable. The following are two examples of work currently underway.

Involvement at all levels of government and in the private sector is critical to transformation

— Community Transformation Partnership (CTP)

The Community Transformation Partnership (CTP) is a coalition of representatives from several mental health consumer, youth and family organizations who assisted in the preparation of the Washington State Transformation Grant proposal, or have expressed an interest in promoting transformation goals. The purpose of the coalition is to create an inclusive statewide structure advancing the state's mental health system transformation efforts. The Transformation Grant has supported the development of this group, but the CTP is a separate entity.

The CTP met for the first time in October 2005, and developed a charter that sets the course for future work. During the first phase of the Transformation Grant the CTP will lay the framework for policy development, education, involvement of consumers and families, evaluation, and the establishment of partnerships with transformation leaders and organizations. While the role of the CTP will evolve over time, depending on the needs of the state project team, the following objectives are examples of activities the CTP expects to accomplish.

- Provide recommendations to the TWG to ensure consumer and family participation on subcommittees and work groups.
- Assist in the development of a consumer conference.
- Assist with recruitment efforts to ensure broad consumer and family involvement in all aspects of the transformation process. This includes community meetings, subcommittees, and work groups.
- Assist in the development and implementation of transformation survey and evaluation projects to obtain consumer and family perspectives.
- Develop workshops and educational programs to widen the transformation process to include consumers and families located at the grassroots level.
- Serve as a focal point for the dissemination of information from the TWG and Transformation staff to organizations, informal networks, and individual consumers and families.

The CTP has been meeting monthly since October 2005 to pursue these goals. Their current focus is on defining their legislative agenda and preparing and offering recovery and resiliency trainings around the state. At their retreat in June, 2006 the CTP further defined its role in forming a legislative policy strategy as stakeholder partners in promoting positive transformation in Washington State. A detailed report regarding the Community Transformation Partnership including a list of the member organizations and their representatives is included in Appendix 4.

— CTP Recovery and Resiliency Seminars

As one of its first tasks, the CTP is developing Recovery and Resiliency training to be implemented throughout the state. These trainings are based on the Substance Abuse Mental Health Service Administration's consensus statement on Recovery and the concept of Resiliency and include the ten fundamental components of recovery (Self Direction, Individualized and Person Centered, Empowerment, Holistic, Non Linear, Strength Based, Peer Support, Respect, Responsibility, and Hope). A nationally known expert on recovery and resiliency will be brought in to conduct a "Train the Trainers" session, anticipated to occur in August 2006. Those trained will then conduct trainings throughout the state.

Initial activities will be dedicated to defining the fundamental principles in detail, and the remainder of the training activities will focus on creating a mechanism to foster advocacy and recovery support at the local level and to connect these communities to the Transformation Grant Process and statewide transformation efforts. The training is being developed by the CTP, through its Recovery and Resiliency Training subcommittee, with financial support from the Transformation Grant.

The purpose of these seminars is to create broad-based recovery and resiliency awareness throughout Washington State's communities

All stakeholders in the Mental Health System will be eligible to attend local sessions. The state anticipates that the seminars will result in at least three outcomes.

1. Transmit the message that mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.
2. Provide general education to providers, consumers of all ages, policy makers and other stakeholders

about Recovery/Resiliency Principles.

3. Create a mechanism to build a grass roots recovery resiliency constituency.

Statewide Adult Consumer Organization

Washington State is in the process of forming a Statewide Adult Consumer Organization that includes a coalition of adult consumer leaders who will ultimately serve as one unified consumer voice to policy and decision-makers. This group will ensure the consumer voice becomes an integral part of the mental health service planning and delivery process.

Potential activities and roles for the organization are varied and inclusive

The statewide adult consumer organization will take on a variety of roles and activities. It is expected to:

- Represent the voice of the mental health consumer and become a critical participant and stakeholder in all statewide mental health policy processes;
- Promote concepts key to the recovery of individuals diagnosed with a mental illness. These concepts include hope, personal empowerment, self-responsibility, respect, and self-determination;
- Promote consumer-established/consumer-operated services as an integral part of the mental health system of care;
- Lend critical support to self-help and mutual support groups and programs throughout the state;
- Play a key role in the development of future state strategic plans;
- Share and disseminate information;
- Provide technical assistance to affiliate groups;
- Educate public officials and the public at large on recovery;
- Link groups together to support each other in their growth and development; and
- Mobilize local communities towards transformation.

Washington has defined the following initial steps for this organization.

Step 1: Identify current or potential consumer leaders representing Washington's counties and tribes.

Step 2: Coordinate an application process to determine membership. Potential applicants will be required to complete an application containing 15 questions around recovery and wellness, self-advocacy, and team-building.

Step 3: Select eight consumers from around the state who will serve as the Selection Committee. The Selection Committee will use a standardized process of reviewing and scoring each application.

Step 4: Announce individuals chosen to serve as County/Tribal Affiliate Leads.

Step 5: Develop the structure of the organization including creating the vision and mission statements, developing bylaws, and establish a board of directors.

Step 6: Provide training in leadership, networking, grassroots organizing, and advocacy skills.

Step 7: Create subcommittees that align with planks at the 2006 Conference Summit. Work with National Self-Help Clearinghouse on identifying major areas of consensus and action steps.

Step 8: Incorporate and apply for IRS non-profit status

Statewide Action for Family Empowerment of Washington (SAFE-WA)

SAFE-WA is currently refining a database to track activities related to consumer involvement in the transformation process. Activities to be tracked are: Changes in consumer advocacy membership; changes in consumer advocacy participation; community contacts via telephone, email and U.S. Postal Service; development of a consumer volunteer base; and other activities that support the President's New Freedom Goals.

SAFE-WA in partnership with Youth 'N Action is working to form a statewide youth leadership structure. SAFE-WA is also working to engage youth participation in relevant policy boards and meeting and other activities. SAFE-WA has sponsored youth and family members to attend conferences at the state and national level. Further, SAFE-WA is conducting Evidence Based Practice and Wraparound Train-the-Trainer sessions for consumers in partnership with local community mental health and family organizations.

Plans for the next year include strengthening the infrastructure of the established organization; focusing on youth in transition; expanding youth & family organizations, building relationships with Tribes and refining details for assessing the number of youth and/or family organizations across Washington State.

College Credited Consumer/Family Training Program

Transformation Project staff are working with key stakeholders to determine the feasibility of developing a 50-credit community college consumers/family training program as part of the workforce development strategy. The project will be assessing its Year 2 strategy and will only implement programs that result in peer counseling jobs at the community mental health centers.

Gap Analysis

The three major themes related to subcommittee recommendations are having clear processes that describe how consumers and families will be involved with the development and delivery of services, that models of self-directed care be implemented, and that funding be available for consumer- and family-run organizations. More specifically, consumers and families will need to address several gaps in the current services delivery system including:

- Cost effective services are not responsive, flexible and provided in the home and in the community as a first and primary choice for consumers, youth and family members.
- Services are often not culturally responsive to consumer, youth and family member needs. This gap leads to unequal access, culturally irrelevant treatments, disproportionality and recidivism.
- Natural and community supports are not explored as a first choice.
- Services are not collaboratively developed, and integrated with formal linkages between agencies perpetuating silos in funding, access and avenues for advocacy.
- Least restrictive and most normative clinically appropriate environments are not readily available. There are too many rules and regulations that create barriers to these services and consumers, youth and family members often are not taught how to understand and navigate the systems that serve them.
- Consumers, youth and family members, cannot fully

participate in planning and delivery of services as essential partners due to the following gaps:

- Meetings are held at times when consumers, youth and family members are at work or at school;
- There is no statewide funding mechanism to compensate consumers, youth and family members for their participation (including child-care);
- Consumers, youth and family members are stigmatized by their involvement in the system instead of being recognized as having valuable expertise in the systems that serve them;
- Transportation in rural areas and food are often not provided; and
- Technical assistance is needed in reducing tokenism and building true partnership relationships based on a mutual respect and understanding.

Illustrated by the above mentioned gaps, it is clear that there are no processes currently in place that describe how consumers, family members and youth will be involved with the development and delivery of services. There is no clear access point for self-directed care interventions. Access to information regarding the latest mental health and other system related findings is not readily accessible or distributed to consumer, youth and family organizations.

Further, although state agency strategic plans do discuss (varies by agency) their proposals, much more detail is needed from each agency to determine how that agency is honoring the subcommittee recommendations.

Next Steps – Year 2-5

Agencies have told the Transformation Project staff that there are many activities they are involved with that are not listed in their strategic plans. We will inventory these strategies for inclusion in next year's plan. Also, state agencies are currently developing budget requests and proposed legislative packages for the 2007-2009 budget period. By September, the agencies will submit these requests to the Governor's Office. Because of the need to finalize the Comprehensive Mental Health Plan by early September, these budget/legislative requests will not be included in the first year's plans. Once we know what is incorporated into the Governor's legislative

package, and which items are supported by the Legislature, a more accurate gap analysis between what the community recommendations and agency activities can be conducted. Once that is done, the state will have a better idea about where to focus its resources to address community recommendations.

Throughout the project process, stakeholders around Washington expressed a desire for a system that is proactive rather than reactive. Governor Gregoire, cabinet-level executives, and members of the state Legislature also acknowledge that a transformed system will need to systematically move away from being *illness* focused towards one that is *health* focused. The strategies defined in this CMHP will drive system level changes that Washington consumers, families, youths and leaders desire.

SECTION 3:

Federal New Freedom Commission Goal #3

Disparities in Mental Health Services are Eliminated.

FEDERAL RECOMMENDATIONS

3.1 Improve access to quality care that is culturally competent.
3.2 Improve access to quality care in rural and geographically remote areas.

Washington is committed to infusing cultural competence into its transformation process

Washington's Comprehensive Mental Health Plan addresses this state's commitment to infusing cultural competence in the transformed system by addressing barriers to treatment, increasing culturally appropriate services to all areas of the state and in all populations served, and in training and recruiting service providers that mirror the cultural make-up of the populations being served.

As part of the transformation project effort, a Cultural Competence Task Group was established to develop specific recommended strategies the state should consider in moving forward in future implementation years.

Overarching principles for infusing cultural competence in the system

The task group identified a number of overarching principles it used to produce its strategies. In order for cultural competence to be operationalized in agencies, institutions, and communities, the following items must be incorporated into the definition of Cultural and Linguistic Competence.

1. Cultural competence is measured by the availability of sufficient numbers of duly qualified personnel and consultants for the system, to provide comparable access to and results from services provided to various communities and populations in the service area of the agency, system or community;
2. The intervention or treatment must be based on cultural values of the individual, group or groups of interest;
3. The strategies that comprise the treatment must be consistent with the values, beliefs and practices of the individual, ethnic of other cultural

groups of interest;

4. Tribal nations must be given due respect for their sovereign status in selecting and receiving mental health service; and

5. Cultural competence requires a thorough understanding of the culture and language of limited English-speaking communities and also of deaf/hard of hearing, deaf/blind and other disability groups, Lesbian, Gay, Bisexual and Transgender, youth, older adults and elder communities.

Task Group Recommended Strategies

In addition to these overarching principles, the following strategies were recommended by the task groups and approved by the TWG to address Presidential Goal #3.

A complete list of strategies and outcomes is included in Appendix 3.

Fiscal Systems Task Group

1. Service equality should be reflected in the distribution of resources and the reimbursement for services across state. Should be a consistent array of services across regions and populations.

Cultural Competency Task Group

1. Require participation of all mental health employees in an initial and ongoing annual training in cultural competence.

2. Recruit and hire employees and leaders that reflect the population they are responsible to serve.

3. Develop and implement a training curriculum for cultural competence in collaboration with institutions of higher education, in particular Schools of Social work and psychology, Public Health, Medicine and Law in order for students and agency personnel to become certified as specialists and future trainers.

4. Revise Washington Administrative Code or MHD-RSN contract terms to afford opportunities for minority specialists to be available to contracting agencies.

5. Create roundtables to discuss and review cultural competence issues routinely with regional service networks, Tribes, mental health providers, and state agency personnel.

6. Identify, implement, validate and support traditional medicines, alternative medicines and cultural traditional approaches that currently exist in the community.
7. Require outreach workers for diverse communities and cultural competence specialists to become a part of the treatment team planning.
8. Provide technical assistance and support to mainstream and specialty mental health provider agencies to promote increased capacity to serve special populations, resulting in development of cultural competence teams that will provide ongoing technical assistance.
9. Provide financial and other incentives for achievement of cultural competence as demonstrated through comparable access and results from service across diverse population groups.
10. Provide social marketing methods as a means to promote and increase cultural competence awareness.
11. Promote the development of linguistically and culturally specific intake and assessment procedures.
12. Provide certified interpreters for deaf/hard of hearing and for limited to non-speaking consumers and family members that are qualified in mental health settings. Done in compliance and alignment with appropriate federal and/or state laws.
13. Develop cultural and linguistic standards and accountability measures.
14. State and local government service agencies and their contractors and Tribes will be responsible for the achievement of cultural/linguistic standards and accountability measures.

Information Technology Task Group

1. Develop on-line training materials. Make sure they are accessible by persons with visual disabilities, and translated into multiple languages. Training materials should include tests of what has been learned as the training progresses. Those tests should be recorded.

Evidence-Based/ Promising/Emerging Practices Task Group

1. Address needs of parenting youth – example Nurse-Family Partnership for all parenting youth or Young Parents Project in Miami-Dade.

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to Federal Goal #3 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Division of Alcohol and Substance Abuse (DASA)

The DASA provides treatment and prevention funding to tribes, minority programs and rural communities to target underserved or hard to reach populations. A portion of the persons served have co-occurring mental illness and chemical dependency.

DSHS, Health and Recovery Administration (HRSA)

The HRSA strategic plans encourage cultural competence through two major efforts: the HRSA diversity plan and the Indian Policy Plan.

HRSA Diversity Plan

HRSA's goal is to build an inclusive work environment and culturally competent workforce for the 2006-2011 period. While HRSA is short of these goals today, it remains committed to improvement by both our mission and policy. The HRSA 2003-2004 Diversity Plan sets forth major goals that are aligned with performance measures in the Assistant Secretary's Performance Agreement.

The primary goal is to recruit and retain a diverse workforce by providing training for key managers and supervisors to ensure that the emerging HRSA Workforce of the future reflects the current commitment to a diverse, culturally competent staff.

A second goal is to support a continuing education environment that promotes cultural competence to the staff so that its importance is recognized in everyday accomplishments and successes.

A third goal is to integrate HRSA's diversity commitment with its business partners and other contractors. Since HRSA is not a primary provider of care a diverse provider base has a high priority because the providers are more readily visible to Medicaid communities than an HRSA staff centered in Olympia.

The HRSA Diversity Plan's final goal is to ensure no disparity of health-care outcomes between ethnic groups. This includes projects like the recent

	outreach into urban African-American families to provide education about breast cancer issues, as well as a Department of Health's plan to recruit, train and retain more providers of diverse ethnic backgrounds. The strategy will emphasize health education, prevention and cultural competence so that clients are better equipped to pass over barriers that now limit access to primary care.
HRSA Indian Policy Plan	HRSA was a pioneer within DSHS in establishing a liaison and ongoing coordination with tribal governments and the American Indian Health Commission of Washington State. HRSA is committed to the Centennial Accord and recognizes its responsibility to consult with tribes on issues of mutual interest and/or concern. That effort is now embedded within the Research and Policy Analysis Division of HRSA, and the tribal liaison officer remains the primary tribal contact for HRSA. HRSA's liaison efforts are coordinated with other tribal contacts in state government, including the DSHS Office of Indian Policy & Support Services. Washington State's medical assistance programs are formally connected with the tribes in a planning document called the "7.01 Updated Report," which is renewed every two years. It commits the administration to full cooperation with American Indians and Alaskan Natives, to share planning and problem solving, and to communicate fully on Medicaid planning and directives. The 7.01 Updated Report is prepared in response to the DSHS Policy 7.01. That policy directs each administration of DSHS to work in consultation with the federally recognized tribes and regonized American Indian organizations to develop a biennial Policy 7.01 implementation plan and annual progress reports that are specific to each region (including headquarters).

DSHS, Mental Health Division (MHD)	Several significant racial and cultural disparities in services are cited in the strategic plan. In response to these trends, MHD's statewide Performance Data Group chartered a work group to examine available penetration and utilization data to determine possible reasons for these disparities. The MHD will prioritize its renewed commitment to comply with DSHS Policy 7.01 and increase government-to-government relations with tribes. The strategic planning process must proceed sooner than time would permit for consultation. MHD anticipates consultation will occur and may result in amendments or revisions to this strategic plan. In the MHD, the regional implementation plans and annual progress reports will be submitted by the RSNs and will be specific to the RSN's Catchment area. Throughout the duration of the 2006-2011 strategic plan, MHD will meet with the Indian Policy Advisory Council in July of each year for ongoing input and comment on the division's strategic plan. The MHD, working with Tribes, will continue to explore and develop methods to facilitate increased government-to-government relations. This exploration continues the work of the 2003 Tribal Mental Health Summit. Currently, the MHD is investigating the use of a Tribal/Children's Long-Term Inpatient Program (CLIP) Administration Memorandum of Agreement to facilitate direct authority by Tribes to refer youth to CLIP facilities.
Department of Health (DOH)	The DOH strategic plan recognizes in its goals and objectives the need to assure the health status of all people in the state, and to hire and retain a diverse complement of staff. The Community and Family Health Division includes reducing/eliminating health disparities as one element of the strategic plan. In the Office of Maternal and Child Health (MHC), reducing/eliminating health disparities is one of nine MCH priorities. The Health Systems Quality Assurance strategic plan includes strategies to: 1) Increase availability of health services in underserved communities, and 2) Increase the number and types of interventions designed to improve equal opportunity to health.

Department of Veterans Affairs (WDVA)

One of the primary reasons WDVA became involved in the outpatient care of veterans with war trauma mental health needs was as a result of the lack of direct services for rural, ethnic minority, gender, and disabled veterans, and the fact that these special barriers prevented access to care. Disparities in level of care, treatment duration, and overall access continue to exist. The flood of new veterans into Washington State has required increases in our traditional efforts in these areas. This influx has prompted the creation of specialized efforts to respond when acute trauma reactions become complicated with delayed treatment, allowing substance abuse and sleep problems. When accompanied by the additional barriers of homelessness and joblessness, these take an even greater toll on WDVA clients. Removing these barriers and bringing treatment and support services to the veteran are major activities for our entire Veteran Services Division. We work at meeting the veteran where he or she is, rather than creating additional barriers. Working directly with our Washington State National Guard units and the many reserve units in our state, allows identification and referral to be done without stigma and shame for those needing help.

Transformation Grant Activities

In addition to the activities being pursued as part of the CMHP, Washington State is exploring additional opportunities to address disparities in the mental health services delivery system.

Public testimony validates concerns that services are lacking in rural areas of the state

Washington embarked on a journey to capture public testimony covering all populations in the mental health system. Responses were recorded and analyzed by research professionals from the University of Washington. In-person public testimony was supplemented by hand-written statements, email, fax, as well as additional documents received from agencies and organizations that could not be present at public input sessions. One key message heard repeatedly is that not only do consumers and providers in smaller, rural areas lack options for treatment, but these areas also receive a disproportionately small share of government funding. This limited funding further reduces the options available. As a result, consumers must often travel great distances to get to treatment centers and even then may have to

travel farther to find services that actually fit their need. Equality of services and funding in all areas of the state would be an indicator of a transformed system.

Washington is working collaboratively with Tribal Governments

Washington State has worked towards developing consistent relationships with Tribal governments within our state. A report addressing this issue in detail is included in Chapter 3.

Washington is using existing commissions to provide advice on specific populations

The MHTP project team has contacted Washington's Cultural Commissions, which fall under the direction of Governor Gregoire. The Commissions that will be actively pursued for input and advice concerning transformation activities include:

Commission on African American Affairs

The Commission on African-American Affairs which examines and defines issues pertaining to the rights and needs of African-Americans, and makes recommendations to the Governor, the legislature, and state agencies for changes in programs and laws.

Commission on Asian Pacific American Affairs

The Commission Asian Pacific American Affairs examines and defines issues pertaining to the rights and needs of Asian Americans and advises the Governor and state agencies on policies, plans and needs.

Hispanic Affairs Commission

The Hispanic Affairs Commission ensures that state programs are providing the assistance needed by the Hispanic community; advises state agencies on developing and implementing policies, plans and programs focusing on the needs of the Hispanic community.

Governor's Office on Indian Affairs

The Governor's Office of Indian Affairs, recognizing the importance of sovereignty, affirms the government-to-government relationship and principles identified in the Centennial Accord to promote and enhance tribal self-sufficiency and serves to assist the state in developing policies consistent with those principles.

Gap Analysis

The primary themes raised in the community process related to this goal are training providers to be culturally competent, ensuring equal access to services regardless of population group or geographic areas, broadening types of services available including alternative or non-traditional services, and eliminating disparities. While there are

numerous activities being implemented to increase cultural awareness, improve cultural competences and eliminate disparities, each state agency is pursuing these objectives independent of the other.

Next Steps – Year 2-5

There is a need to inventory the strategies currently in place to identify what is and is not working. It may be possible to share strategies across agencies to not only create efficiencies, but to improve effectiveness in achieving community recommendations. Because the state agencies will not release their 2007-2009 proposed budgets to the Governor until September 2006, and since agencies have not listed all of their strategies in their strategies plans, there will be a need to re-visit proposed strategies and gaps after the Comprehensive Mental Health Plan is submitted. Once that exercise is completed, the Transformation Project staff can work with state agencies to determine which strategies recommended in this report will be pursued in the next year.

SECTION 4:

Federal New Freedom Commission Goal #4

Early Mental Health Screening, Assessment and Referral to Services are Common Practice.

FEDERAL RECOMMENDATIONS

4.1 Promote the mental health of young children.
4.2 Improve and expand school mental health programs.
4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Consistent screening and assessment processes are needed on a statewide level

Consumers and professionals provided significant feedback during the Year 1 of the MHTP that a lack of consistent screening and assessment tools and processes are contributing to inconsistencies in the availability and quality of services, depending on the consumer's location. This inconsistency is seen as a priority for both consumers and treatment professionals in transforming the mental health system.

Subcommittee Recommended Outcomes

In response to the New Freedom Commission recommendations, the following outcomes were recommended by the subcommittees to address Presidential Goal #4.

A complete list of strategies and outcomes is included in Appendix 3.

Co-Occurring Disorders Subcommittee

1. Consumers will have access to appropriate, quality treatment regardless of barriers and/or resources.
   - Services will be specific to the individual's needs.
   - There will be access to sufficient treatment providers who trained and retained.
2. Affected parties are informed, educated and knowledgeable about co-occurring disorders and their recovery culture, principles and philosophy.
   - Peer-to-peer support is available to all who want it.

	• Communication between and among the parties is critical to making this successful. • Law enforcement officers receive crisis intervention training to deal with co-occurring disorders. 3. Increased system collaboration and service integration is prevalent across all allied systems and services. • Reduction in silos across system boundaries; • Increased holistic services; and • Increased cross-system treatment.
Youth in Transition Subcommittee	1. Seamless, holistic care to include mental health, physical health and dental integrated for all youth 13 – 24 that provides for access on demand and includes early identification, intervention, housing, benefits and transition to adulthood. Systems use practices that have been known to work. 2. Continual quality improvement is an integral part of all systems based on feedback and involvement from youth consumers and family members.
Older Adult Consumers Subcommittee	1. Older Adults will have improved and consistent access to appropriate mental health services, including outreach to place of residence. 2. Appropriate mental health services for older adults are coordinated across all systems of care at state, regional and local levels.
Children/Youth & Parents/Families Subcommittee	1. Training and Education This is inclusive of partnerships that would include parents/youth and professionals as trainers, who are responsive to cultural diversity, which goes beyond linguistics and ethnicity. • Trainings would include a basic level of information regarding mental illness and strategies and interventions about how to deal with issues as they surface. Trainings would be targeted towards teachers, in an effort to help stabilize children and youth experiencing mental illness in the school environment. Trainings for parents, kinship caregivers, adoptive parents and foster parents would include behavioral intervention and crisis

management skills. Other professionals also need to be trained and all trainings need to start early and include Birth to Three issues.

2. A system that is more proactive than reactive.

   Serve the WHOLE family with a full continuum of community-based services, starting with prevention and early intervention. Services would be available for parents/caregivers when the child is in an out-of-home placement even though the parent may have lost their Medicaid coupon. There would be a wide range of available individualized services in the community that are supportive to families so they can keep their child at home and not give up custody so their child can get services.

   Additional services in the continuum would include respite, Wraparound services, day treatment, and evidenced-based programs. They would build on family strengths and resiliencies and support parent partnering, and would be well coordinated (seamless) among the systems. Services would be available to be delivered in the family home or other community locations or family preferences.

   - Revisit the Access to Care Standards and open the door to access.
   - Decrease in families seeking Voluntary Placement Agreements.
   - Increase in mental health treatment and community supports for parents/caregivers and their children to keep children in their homes or successfully return children to home after an out of home placement. (Children may be returning from JRA, CLIP, or CA, for example.)
   - Increase in community services and supports for families. This includes respite, Wraparound services, day treatment and evidenced-based practices.

Task Group Recommended Strategies

The following strategies were recommended by the task groups to address Presidential Goal #4.

Fiscal Task Group

1. Expand availability of early intervention and assessment for all populations.

Information Technology Task Group

1. Develop and pilot a consumer-focused, consumer-driven, recovery-focused needs assessment screening tool for mental health and alcohol/drugs that can be used across multiple settings.
2. Develop a website for each consumer that contains an assessment tool and its accompanying treatment goals, which can be edited as treatment progresses, and accessed if the consumer gives permission.
3. Be sure that the common screening and assessment tool include the date the service need is identified and application is made.

Evidence-Based/ Promising/Emerging Practices Task Group

1. Specifically address provision of appropriate infant, toddler and early childhood mental health services.
   - Statewide adoption of the DC:0-3R for children Birth through five years of age.
   - Provision of appropriate relationship-based services when possible and appropriate.
2. Create a statewide Mental Health Technical Assistance, Training and Resource Center that is modeled off of the national technical assistance centers.
3. Use Depression Care Management (e.g. IMPACT, PROSPECT)
4. Implement Gatekeeper programs
5. Use the Program to Encourage Active and Rewarding Lives for Seniors
6. Geriatric Regional Assessment Team
7. Case Management
8. Elder Wrap Around
9. Expanded Community Services
10. Ensure that a specific component of the statewide training and technical assistance center

is directed at education for Primary Health Care Providers (PHCP).

11. Utilize models incorporating aspects of cognitive behavioral therapy and Motivational Enhancement Therapy for integrated treatment for co-occurring mental health and substance abuse disorders.
12. Utilize contingency management strategies to support recovery.
13. Utilize integrated group therapy.
14. Treatment for parents in particular should incorporate trauma treatment into substance treatment approaches.
15. Screening and treatment should deliberately inquire whether clients are parenting and how these challenges impact their parenting and family relationships.
16. Implement Crisis Intervention Team (CIT) model for law enforcement officials.
17. Use peer support models such as dual recovery and double trouble.
18. Integrate systematic screening for mental health and substance use.
19. Co-treatment oriented courts (such as Family Treatment Court, Drug Court, Mental Health Court).
20. Implement a statewide approach to supporting school staff to help stabilize children and youth experiencing mental illness in the school environment. Specifically consider Positive Behavioral Interventions and Supports.
21. Provide Co-occurring disorders training.
22. Provide Expanded Community Services.
23. Use individual placement and support.
24. Consumers will be required to complete their own Life Analysis, which takes the place of a professional generated Treatment Plan. The Life Analysis identifies recovery goals, and what is needed to accomplish those goals.
25. Restructure the Access to Care Standards to ensure treatment can easily be provided:

- in a non-clinic setting (home, childcare center);
- to caregiver-child dyads and other family constellations;
- for disordered relationships even without a presenting primary diagnosis in the adult or child;
- for caregivers with mild to moderate mental health challenges with a specific focus on mitigating the impact of their mental health challenges on parenting;
- for children at-risk of developing severe emotional-behavioral disorders;
- for children exposed to trauma or violence regardless of presenting diagnosis; and
- for drug-exposed infants and their caregivers regardless of presenting diagnosis.

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to Federal Goal #4 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Aging and Disability Services Administration (ADSA)

ADSA is developing community resources for specialty services such as individuals with Traumatic Brain Injury, chemical dependency needs, mental health needs, behavioral issues and dementia. Some of this work has occurred in collaboration with other systems, including the Mental Health Division. More detailed plans will be developed over the next year.

ADSA plans to increase community services for people with mental illness and long term care needs. ADSA is also working with the Mental Health Division to ensure appropriate services are provided to ADSA clients in state psychiatric hospitals as well as planning community alternatives to state hospitals. These activities may require legislative changes, budget enhancements and Medicaid waiver revisions. Finally, ADSA is revising its assessment tool to better identify behavioral issues to improve identification of client needs.

DSHS, Division of Alcohol and Substance Abuse (DASA)

Over the past several years, chemical dependency treatment providers have received substantial training in the screening, assessment, and treatment of patients with co-occurring mental health and

substance abuse disorders. Referrals between systems have increased, as have the opportunities to provide integrated treatment.

With the passage of Engrossed Second Substitute Senate Bill 5763 (E2SSB 5763) – the Omnibus Mental Health and Substance Abuse Treatment Act – in 2005, mental health and chemical dependency treatment providers are moving toward use of a common integrated protocol for the screening and assessment of mental health and substance abuse disorders.

DASA is undertaking a number of strategies to improve screening, assessment and referral processes.

- All treatment clients must be screened for mental health needs and services are coordinated with mental health providers as appropriate.
- All residential programs for youth and pregnant/parenting women must offer on-site mental health counseling. Also, pregnant/ parenting residential programs offer parenting classes and therapeutic childcare for young children who reside in the treatment facility with their mothers.
- Chemical dependency counselors have been placed in a number of group homes to serve youth with emotional/behavioral disorders.
- Mental health counseling must be available in all residential involuntary commitment programs and secure detoxification facilities.

In addition, DASA is coordinating with the DSHS Children's Administration to co-locate chemical dependency counselors in local Children's Services offices to conduct screening, assessment, and referral to chemical dependency treatment and monitoring of treatment progress for parents involved in the child welfare system.

DSHS, Mental Health Division (MHD)

As part of E2SSB 5763, the Mental Health Division is required to develop an integrated and comprehensive screening and assessment process for chemical dependency, mental disorders, and co-occurring chemical dependency with mental disorders. A cross-agency team that includes MHD, DASA, DOC, and the Washington Institute for Mental

Illness Research and Training (WIMIRT) has begun implementation of this work, with input from RSNs and mental health providers. Screening tool recommendations have been established, and will be presented to interested stakeholders in August. An assessment process team, including RSN administrators, is also being assembled and will join the cross agency team to develop the assessment process.

MHD's strategic plans contain the following strategies.

- Promote the mental health of all citizens across life spectrums and ethnicity and cultures.
- Promote screening and early intervention in primary health care facilities and schools [e.g. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)] thereby actively promoting the expectation of comparable decreases in instances of mental health crisis later in life. EPSDT includes regular checkups for children to make sure they get immunizations and other preventive care needed to detect and treat health problems at an early stage
- Collaborate with other state agencies serving children and their families to provide screening for children and youth in potentially high-risk settings such as child welfare and juvenile justice settings.
- Build on service coordination and collaboration developed as part of the Children's Mental Health Initiative (Children's Administration, Juvenile Rehabilitation Administration, and Mental Health Division).
- Provide training for primary health providers to screen for and recognize early signs of emotional and behavioral problems, and to offer connections to appropriate interventions.
- Provide information, support and treatment for parents who are experiencing mental health problems to allow them to better address the needs of their children.

Improve and expand school mental health programs.

- Collaborate with other state agencies serving children and their families to address the mental health needs of children and youth in the education system.
- Develop a continuum of care to provide services and supports for children and youth in schools that includes training, prevention, early identification, early intervention, and treatment.
- Provide consistent state-level leadership and collaboration between education, general health, and mental health.

Screen for co-occurring mental and substance abuse disorders and link with integrated treatment.

- Collaborate with other state agencies serving children and youth to screen for co-occurring mental health and substance abuse disorders in the juvenile justice system.
- Collaborate with other state agencies serving children and youth to screen for co-occurring mental health and substance abuse disorders in the child welfare system (such as children in foster care).
- Identify and initiate coverage for core components of evidence based collaborative care, to include a comprehensive range of treatment modalities, i.e. clubhouses, peer counseling, respite care, and supported employment.
- Involve consumers and their caregiver advocates in program design and advocacy.
- Investigate the use of blended and braided funding to provide integrated programming.

Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

- Identify and consider coverage for core components of evidence-based collaborative care, to include case management and disease management.
- Expand mental health services in all residential and community care settings.

- Provide consultation to primary care providers by mental health specialists that do not involve face-to-face contact with consumers.
- Provide expanded Gatekeeper programming as an outreach to older or isolated individuals who may benefit from behavioral health screening.
- Implement a comprehensive screening process to promote early intervention and treatment for people with mental disorders, including dementia.

MHD is also involved in emergency management planning work with the Federal Emergency Management Administration (FEMA) and plays a role in planning for a statewide comprehensive response. Specific tasks assigned to the mental health system include:

- Assist in assessing the mental health needs of the population,
- Provide mental health training materials for system emergency preparedness,
- Assist in arranging training for mental health outreach worker,
- Assess the adequacy of application for federal crisis counseling grant funds,
- Address worker stress issues and needs through a variety of mechanisms, and
- Maintain a current roster of available staff that can be utilized to assist in major crisis.

DSHS Juvenile Rehabilitation Administration (JRA)

JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. Strategic planning goals include the development of a culturally competent assessment process in conjunction with expanded, community residential-based continuum of service for youth in the justice system with mental health needs.

Department of Corrections (DOC)

All offenders will be screened for their strengths, deficits and needs. Each person will have an Offender Personalized Plan that will include community risk, vocational and health needs, including mental health. Research based interventions will be implemented in the institutions that carry the most promise for creating a readiness for community re-entry. Finally, community services, including mental health

counseling, will be focused on those services most likely to reduce re-offense rates and assist offenders in community integration.

Department of Early Learning (DEL)

In the 2006 Legislative Session, Washington created a new cabinet-level agency, the Department of Early Learning. Only officially in existence since July of 2006, the Department is already working with other entities to identify partners in their mission, and have assigned management-level focus on the MHTP. The Early Learning Advisory Council, with legislative and executive participation, is at the forefront of defining the agenda and includes expectations addressing child well-being. The MHTP is working to engage this important partner.

Department of Health (DOH)

A major objective of the DOH strategic plan is to assure people have the information they need to prevent disease and injury, manage chronic conditions, increase healthy behaviors, and make healthy decisions. The Community and Family Health Division strategic plan calls for programs that promote a healthy start, healthy choices, and access to services.

The Office of Maternal and Child Health provides quality screening, identification, intervention and care coordination.

Department of Veterans Affairs (WDVA)

The agency's focus is on the detection, treatment, and referral of veterans. Agency staff are sensitive to the special needs of veterans, and seek to support each veteran through the often difficult process of obtaining entitlement help from the federal Veterans Administration (VA). This proactive "*early is better"* approach to assessment and referral is pervasive throughout the agency's network of service officers, specialized outreach programs, Veterans Homes, and the War Trauma/PTSD Program. Since the start of the current war WDVA has been very proactive in their work with the federal VA, the Department of Defense, Washington State National Guard, and the many military reserve units all around the state. Almost every weekend, there is at least one event where on-site mental health counselors are on hand to administer standardized screening tools, to present information regarding readjustment, or to simply be available for anyone wanting to talk. The formal process often includes both screening and private interviews with the soldier and/or family member.

These meetings lead to referral via a mechanism that bypasses waiting lists and other delays. Since the agency has worked to make the links to all services to veterans seamless, a veteran can see a counselor on Saturday, and be scheduled for follow-up appointments on Monday, with either a state or federal provider, which ever is best suited to the veteran's needs.

Gap Analysis

The analysis of agency strategic plans point to numerous gaps that need to be addressed in order for transformation to take effect. While some recent and current efforts are laudable, coordinated, uniform approaches across agencies would effectively reduce costs and create smoother access for consumers and families. Particularly with young children, careful crafting of policy to include common diagnostic standards, common treatment approaches and clarity for consumers and professionals regarding screening, assessment and treatment referral would significantly improve outcomes.

Screening and Assessment

While recent legislation has established a common screening and assessment approach across the addiction and mental health systems, not all agencies are using standardized instruments for screening and assessment. Some agencies are advancing the use of standard screening, but there is a lack of clarity regarding the services that would be indicated through screening programs. Schools, child care systems and the child welfare agency would benefit from standardized models for referral and care. Referral policies vary across these systems and there is confusion regarding eligibility. When the treatment of children with emotional disturbance requires services for their parents, the systems often break down attempting to determine which agency or service system is responsible.

Access to Care Standards

The state's Access to Care Standards are established to determine eligibility for the current RSN service structure and focus heavily on current clinical diagnoses (e.g., Diagnostic and Statistical Manual 4), often keeping Medicaid eligible individuals from accessing appropriate, early care. Children and families are often caught in a vicious circle, where Medicaid eligibility is established, but no clear care system is available for referral. Medicaid eligible children and their families have no service structure through the RSN structure that will pay for needed

services. Primary care will provide assessment, but no provider service system is available that can be reimbursed through Medicaid.

School Systems

State public education systems have fragmented mental health service strategies, dependent largely on the innovation of individual districts rather than a state policy for mental health care. The state's recent creation of the Department of Early Learning and the Washington Learns Initiative are promising opportunities to improve school mental health service, but a consistent set of policies is yet to emerge.

Prevention/Early Intervention

Prevention programs in Washington State are fragmented, un-coordinated and tend to focus on specific issues/populations without regard for public health science that recognizes common risk and protective factors. While individual programs are excellent and well designed, mental health is often absent from the ongoing collaboration between the key players. The Transformation Project has brought together prevention experts from across disciplines (See Chapter 4 - *Prevention*) but significant work is required to begin crafting a statewide, multidisciplinary approach that brings mental health into focus

Next Steps – Year 2-5

During Years 2 -5 the Transformation Project will focus on several priority activities related to Goal #4 include:

- Promoting the current effort to standardize screening/assessment processes,
- Continuing development of effective school based policies,
- Partnering with schools, early learning, child care and child welfare efforts,
- Continuing development of a state prevention policy, and
- Continuing development and assessment of strategies that cross the life span.

SECTION 5:

Federal New Freedom Commission Goal #5

Excellent Mental Health Care Is Delivered and Research Is Accelerated.

FEDERAL RECOMMENDATIONS

5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Washington's strategy for defining practices and research priorities is inclusive of partners at all levels of the delivery continuum

Washington has defined a clear strategy for ensuring practices that best meet consumer needs are pursued. In tandem with these strategies, the MHTP is increasing research efforts that effectively target services that provide consumers the most effective options. The MHTP is ensuring consumers, advocates, clinicians, administrators, and researchers are fully engaged in the transformation process through the Evidence-Based, Promising and Emerging Practices (EBPEP) Task Group.

The EBPEP task group defined the scope of strategies in the most inclusive way possible, consistent with the scope of the project. Informed by the evolution of the concept of evidence-based practice in the scientific literature and the philosophy developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) the types of strategies included in the task groups' efforts target three types of practices (evidence based, promising, and emerging) and more general system strategies.

Subcommittee Recommended Outcomes

In response to the New Freedom Commission recommendations, the following outcomes were recommended by the subcommittees to address Presidential Goal #5.

	A complete list of strategies and outcomes is included in Appendix 3.
Criminal Justice Subcommittee	1. Decrease the number of people with mental illness from entering into the criminal justice system.
	2. Increase access to mental health and substance abuse services for those within the criminal justice system.
	3. Decrease the number of people with mental health illness re-entering the criminal justice system
Co-Occurring Disorders Subcommittee	1. Affected parties are informed, educated and knowledgeable about co-occurring disorders and their recovery culture, principles and philosophy.
	– Peer-to-peer support is available to all who want it.
	– Communication between and among the parties is critical to making this successful.
	– Law enforcement officers receive crisis intervention training to deal with co-occurring disorders
Youth in Transition Subcommittee	1. Consistent access to quality services and supports available regardless of location or funding sources.
Adult Consumers and Families Subcommittee	1. The ombuds system is independent of the mental health system (MHD, RSNs, and provider agencies).
	2. Everyone working in the mental health system is trained and certified in psychiatric rehabilitation through college programs specially designed to provide such training. All recipients of services are also trained in psychiatric rehabilitation.
Older Adult Consumers Subcommittee	1. Mental Health services for older adults will be provided and funded in an integrated holistic model of care including mental health, medical, substance abuse, social services and spiritual.
	2. There will be an increased number of service providing individuals with professional experience in mental health and aging.
Homelessness subcommittee	1. Services are available immediately, regardless of the financial or categorical status of the individual or family, while other benefits and services are

	being applied for. 2. Housing will be available immediately upon need for individuals/families. 3. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).
Children/Youth & Parents/Families Subcommittee	1. Greater availability of state-only funds. This would require a decrease in requirements around State-only funds and an increase in the flexible use of these funds. With that in place we would purchase with: • State-only funds for parent organizations, mentorships; • State-only funds to serve those who are not in the country legally, non-Medicaid children/youth and families; and • State-only funds to serve working poor and people who have exhausted their insurance benefits
Task Group Recommended Strategies	The following strategies were defined by the MHTP Task Groups in response to Presidential Goal #5.
Fiscal Task Group	1. Seek to reduce funding silos and increase/expand integration of funding streams; seek waivers to expand integration. 2. Reimbursement should be outcome based with incentives for adopting evidence-based practices.
Cultural Competency Task Group	1. Support efforts to document and validate emerging programs and practices and disseminate promising programs and practices statewide. 2. Identify, document, validate implement, and support promising programs and practices that currently exist in the community. 3. Publish reports, whenever possible, that distinguish outcomes by subgroup – demographic, ethnic, geographic.
Information Technology Task Group	1. Expand existing cross-agency outcome database to each consumer receiving public or charity funded health, mental health or alcohol/drug services from any local or state agency, jail,

prison or hospital.

- Include outcomes drawn from public records of important life and recovery issues (such as employments, arrests, graduations, hospitalizations, and marriages).
- Develop and pilot consistent survey measures for those outcomes that cannot be gathered from existing agency records.

2. Use Outcome Database, adjusted for differences between treatment and comparison groups using the assessment and diagnostic information.
    - Publish reports, whenever possible, that distinguish outcomes by subgroup – demographic, ethnic, and geographic.
3. Use Outcome Database to monitor client outcomes resulting from services received from various mental health and AOD treatment providers. Adjust for differences in populations served using the assessment and diagnostic information from Strategy 5.
4. Develop a training and quality assurance database on selected evidenced-based practices.
5. Cost out various alternatives for charging services; choose one and implement it.
6. Require consumer-run services to enter persons served, frequency and dates of services. Best method might be a website using an ID card, or a web-accessible database.
7. Develop maps and directories of service providers by specialty area. Include the private providers. Generate lists from licensing databases, expanded 911 lines, crisis and referral databases and other frequently updated directors. Allow providers to self-refer to the lists, with references.

Evidence-Based/ Promising/Emerging Practices Task Group

1. Develop mechanism for supporting relationship development maintenance between incarcerated parents and their children (e.g., TAMAR's children model).
2. The MHD will pilot two self-directed care programs, one in Eastern Washington and one in Western Washington, based on the Florida SDC Model.
    - Consumers in this program will be paired with a trained life coach who will act as a brokerage support to assist in the overall design and management of their self-directed care plans.
    - Consumers in this program will be eligible to purchase services for the purpose of accessing:
        - Clinical Recovery Services,
        - Psychological Assessment,
        - Medical Services (Psychiatric Evaluation, Medication Management),
        - PACT,
        - Individual and Group Therapy provided by a licensed mental health professional, and
        - Supported Employment.
    - Recovery support services (services that are alternative to traditional mental health services) such as:
        - Massage therapy as a form of touch therapy to assist an individual overcome issues documented by a licensed mental health professional;
        - Forms of art therapy;
        - Smoking cessation activities Occupational, speech, and physical therapy when recommended by a licensed mental health professional; and
        - Services related to developing employability and/or productivity that will lead to employability.

- Recovery enhancements (tangible items for consumption that relate to employment or other productivity such as volunteer work or training/education) including:
  - Transportation,
  - Non-cosmetic dental work,
  - Hearing aids,
  - Non-cosmetic eye glasses and non-disposable contacts, and
  - Other specific enhancements that relate to employment and productivity in consumers' communities are enumerated in the Task Groups report.
- Consumers will be provided comprehensive informational supports about medication assistance, treatment options, and potential providers.
- Consumers will be encouraged to complete an Advance Directive; Relapse Prevention Plan; Crisis Plan; Personal Safety Plan; and Post Crisis Plan. The goal is for participants to take control of their own lives, and not be controlled by their illness, circumstances, or others.

3. Increase Wraparound services with a specified model that includes quality monitoring.
4. Adopt a comprehensive collaborative mental health-juvenile justice strategy for intervening at critical points in juvenile justice processing (initial contact, intake, detention, judicial processing, placement, probation, aftercare).
5. Perform mental health screening and assessment routinely as youths move from point to point in the juvenile justice system.
6. Provide evidence-based treatment models while within the juvenile justice system.
7. Jointly establish procedures and policies for identifying youth who are appropriate for diversion.
8. Institute and evaluate diversion mechanisms at every key decision-making point within the

juvenile justice continuum.

9. Provide Crisis Intervention Training to Police Officers.
10. Arrange for continued access to evidence-based care upon release including models such as Multi Systemic Therapy, Functional Family Therapy, and Family Integrated Transitions.
11. Use Life skills development curricula that includes mental health education component (examples include MOVE, TARGET-T).
12. Use navigators and peer advocates.
13. Integrate centers for health, mental health and life skills support (example school health clinics).
14. Use Transition centers.
15. Address needs of parenting youth – example Nurse-Family Partnership for all parenting youth or Young Parents Project in Miami-Dade.
16. Use Empowerment and Engagement curricula (examples MOVE, TARGET-T).
17. Develop institutionalized consumer advisory boards.
18. Depression Care Management (e.g. IMPACT, PROSPECT).
19. Include inquiry into provision of care giving to children.
20. Continue Geriatric Mental Health Specialty Training.
21. Provide co-occurring disorders training.
22. Implement a consistent statewide approach to ensuring that family mental health supports are available for all family members (Birth on up) during both periods of homelessness and transition.
23. Use multi-disciplinary teams including mental health and chemical dependency specialists, RN/ARNP, case managers, and peer supports are available at drop in centers and shelters to provide assessment, services and supports.
24. Make available Medical Respite for youth and young adults.

25. Make needed mental health and general community support services immediately available to those requiring assistance in process of stabilizing while entitlements are pursued.
26. Implement PACT teams.
27. Establish a medication initiation and maintenance service that can be quickly and easily accessed by people without Medicaid or those with Medicaid who have not been able to get enrolled in community mental health services.
28. Create an ample supply of outreach and engagement teams aimed at identifying, engaging and stabilizing homeless persons with mental disorders.
29. Programs are developed for youth and young adults that are developmentally appropriate and meet the unique, individualized needs of this population. Such models should include access to and availability of comprehensive support services including mental health, substance abuse, independent living skills, and vocational training are provided to assist youth and young adults in maintaining housing (Local examples – Youth Care Model, Mockingbird Family Model programs).
30. Develop a statewide Youth and Family Engagement Academy to mobilize funding, develop training, and match family and/or youth involvement models to community needs.
31. Establish Housing First: Large investment in development of enough permanent subsidized housing to meet the needs of all homeless people with mental illness. Appropriate supportive services need to be attached to housing.
32. Establish some transitional housing options to provide for overflow need.
33. Use 4-year and 2-year colleges to train professionals and para-professionals in psychiatric rehabilitation.
34. Encourage reinstatement of psychiatric rehabilitation programs at Washington State University and in the Eastern Washington University Social Work departments and in additional undergraduate schools.

35. Develop certificate and AA programs at community colleges in alignment with USPRA program requirements.
36. Establish a Recovery Education Center School that would be licensed by the State of Washington (e.g., college degree in behavioral health recovery).
37. Establish Recovery Schools as a post-secondary educational institution.
38. Identify early childhood aggression and implement evidence-based practices around responding to early childhood aggression and conduct problems (e.g., the Incredible Years program).
39. Work with the schools to increase early identification of emerging aggression, conduct problems, and delinquency and implement evidence-based interventions.
40. Establish treatment courts and court-based-interventions for youth and parents/caregivers with MH or SA disorders resulting in child abuse or neglect. (e.g. Family Treatment/ Dependency Court, or the Miami-Dade Infant Mental Health Court).
41. Establish treatment courts and court-based interventions for adult offenders with mental illness.
42. Establish local Triage Centers.
43. Undertake a comprehensive, cross-system financing strategy for child, youth, and family mental health that aims to maximize federal entitlements, increase flexibility, and fit state-only funds to state and local needs.
44. Collaborate with Insurance Commissioner around options for ensuring EBTs are reimbursable through private insurance plans.
45. Ensure that a specific component of the statewide training and technical assistance center is directed at education for Primary Health Care Providers (PHCP).
46. Implement a statewide approach to supporting school staff to help stabilize children and youth

experiencing mental illness in the school environment. Specifically consider Positive Behavioral Interventions and Supports (PBIS).

47. Cross train DVR staff and clinical and vocational mental health staff to increase integration and communication.

48. Treatment of parents in particular should incorporate trauma treatment into substance-treatment options.

49. Screening and treatment should deliberately inquire into if clients are parenting and how these challenges impact their parenting and family relationships.

50. Create an Evidence-Based/ Promising/Emerging Practice (EBPEP) Institute to provide mechanisms to:

- Provide oversight and direction toward the implementation of EBPs including consumers, parents, and youth;
- Review, monitor, and disseminate information on evidence-based practices and current research;
- Assist communities to identify local needs, select evidence-based approaches and provide technical assistance for implementation; and
- Evaluate and maintain strategies including evaluating current and new practices and monitoring for fidelity and outcomes.

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to Federal Goal #2 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Division of Alcohol and Substance Abuse (DASA)

The DSHS Division of Alcohol and Substance Abuse (DASA) conducts extensive evaluation and research projects. Some of these projects have explored whether clients with co-occurring disorders have equal or worse outcomes than those with chemical dependency only. More of this research will be conducted in the future as evidence based practices for co-occurring populations are implemented.

Washington Medicaid Integration Project (WMIP)	DSHS implemented an initial pilot project of WMIP in Snohomish County in the fall of 2004 to provide integrated medical, behavioral health and long-term care services for approximately 6,000 aged, blind and disabled clients. Medicaid clients who voluntarily join the project have benefited by a "medical home" in the provider network furnished by the managed care vendor contracted to integrate current services (including drug and alcohol treatment, mental health care, and medical services). HRSA is also the lead administration in the Medicaid Integration Partnership, an effort that brings together all of the Medicaid funding streams in DSHS to create a new delivery model that is client-centered and efficient. Participating administrations include Aging and Disability Services Administration (long-term care) and DSHS's Division of Research and Data Analysis.
General Assistance – Unemployable Managed Care Pilot	HRSA is currently setting up a pilot project in King and Pierce counties (the state's largest urban population) to deliver health care services to persons eligible for general assistance through DSHS. This population is often characterized by the existence of mental illness and homelessness. The pilot project is being designed to: • Maximize care coordination, high-risk medical management and chronic care management, • Improve our citizens' health by purchasing evidence-based health services, • Establish evidence-based decision-making processes that will increase the explicit use of current best practices in making care decisions, • Establish incentives for providers, using evidence-based health promotion and disease prevention programs, • Increase educational opportunities for providers on the evidence-based process and how to access information to support their decisions, and • Establish a process to determine which benefits and related scope are most likely to improve and maintain the health status of HRSA clients in an efficient manner.

DSHS, Mental Health Division (MHD)	Two recent pieces of legislation are supporting the MHD's strategic planning process. Engrossed Second Substitute House Bill (E2SHB) 1290, passed in 2005, promotes public policy focused on mental health treatments and services that are evidence and research-based [meaning they are programs or practices that have demonstrated results in clinical trials or have some research demonstrating effectiveness but do not yet meet the standards of evidence-based practices (EBPs)]. The legislation also aims to ensure public mental health services are delivered efficiently, effectively, and consistently across the state. Coordination of services within the department is emphasized and includes partners outside of DSHS such as the Office of Superintendent for Public Instruction, state mental hospitals, county authorities, community mental health providers, and other support services. Such coordination will also include families and advocates of persons with mental illness to the greatest extent possible.
Crisis Response Pilots	Engrossed Second Substitute Senate Bill (E2SSB) 5763, also passed in 2005, integrates treatment of co-occurring mental and substance disorders to achieve successful outcomes and recovery. The bill also directed DSHS to contract for two pilot sites (one urban and one rural) to test changes to the chemical dependency involuntary treatment law. The pilots will integrate mental health and chemical dependency crisis response, and allow for 72-hour detention and 14-day commitment into a secure detoxification facility. The department invited all counties in the state to submit proposals for the Integrated Crisis Response Pilots. Two successful bidders were chosen and became operational March 1, 2006: Pierce County and the counties that make up the North Sound RSN. MHD and DASA have developed contracts for the services and a training curriculum for the designated crisis responders.
Children's Mental Health Initiative	In December 2003, the Assistant Secretaries for Children's Administration (CA), the Health and Recovery Services Administration (formerly Health and Rehabilitative Services Administration), and the Juvenile Rehabilitation Administration (JRA) convened a work group to address the mental health needs of children and youth who are served by these

three systems within DSHS. The DSHS Children's Mental Health Workgroup published a report in July 2004. Two significant themes that received attention both within the Workgroup and from stakeholders were the dynamic tension between statewide consistency and local discretion, and a perceived gulf between family-driven, culturally appropriate services and EBPs.

The Workgroup set forth several recommendations that addressed these tensions:

- Implement evidence-based care statewide and develop a common approach for the provision of mental health services for consumers across the life spectrum using evidence-based practices.
- Work with MHPAC on evidence-based practices (EBPs) and promising practices to identify needs and barriers to EBP implementation. Develop clear funding streams and start up costs associated with each EBP.
- Develop requests for legislation to solicit on-going funding for EBPs not covered by Medicaid.
- Provide training and technical assistance and follow-up to sites implementing currently defined EBPs.
- Develop policies and monitoring strategies for EBPs (to include fidelity assessments, incentives, increased monitoring of consumer outcomes, and a process for incorporation of new EBPs).
- Develop reporting guidelines for EBPs.
- Showcase MH agencies with effective EBPs.
- Collaborate with other DSHS agencies to implement cross-system EBPs.
- Provide training, technical assistance for evaluation, and follow-up of new promising and innovative practices.
- Continue review of clinical practices, with inclusion of promising practices as they become supported by evaluation and consumer outcomes.
- Meet with SAFE-WA to discuss and receive input with regard to the best approaches for including families and youth in the provision of services.

- Meet with Health Action to discuss and receive input with regard to the best approaches for including youth in the provision and development of services to youth.
- Support the increased involvement of youth in system development.
- Track the progress of joint strategies developed with other administrations and divisions.

Develop an information system that integrates quantitative and qualitative data across the mental health system and facilitates access to reports.

- Build on existing information systems to incorporate and integrate computerized data from Quality Assurance and Improvement (QA&I) reviews.
- Build on existing information systems to incorporate and integrate other qualitative data (e.g. OCA, QA&I, Ombudsmen, and P&P).
- Better integrate information systems throughout DSHS to better identify older adults service needs for the development of more specific outcome measures.

Use performance indicator reporting to manage and improve the mental health system through contracts and quality improvement efforts.

- Develop Performance Indicators from the consumer outcome system.
- Develop Performance Indicators that are specific to older adult issues.
- Develop consensus within MHD about goals/benchmarks for these performance indicators.
- Maintain involvement in national performance indicator efforts through CMHS, NASMHPD, ACMHA, NCQA, and JCAHO.
- Develop positive incentive system for RSNs following JLARC recommendations.
- Develop system to recognize programs/providers/RSNs that exceed expectations or demonstrate best practices.

	RSNs/PIHPs are implementing protocols for service delivery for the provision of services to children and youth who receive services through cross-system initiatives. These protocols were designed with the assistance of care providers, parents and other concerned citizens. RSNs/PIHPs have been involved in the design of the services for hard-to-place adolescents and they have been involved with the DSHS Children's Mental Health Workgroup discussed above.
Children's Mental Health Pilot Project	The Mental Health Division received funding to establish a pilot program to provide evidence-based mental health services to children. In collaboration with the JRA, MHD will be preparing a request for proposal to solicit bids from potential contractors. The department, in consultation with a broadly representative group of individuals with expertise in children's mental health, will establish a list of evidence-based mental health services that the pilot sites can choose to provide. The project will require significant collaboration between all of MHD's service partners including agencies and community partners. In addition, the University of Washington will provide expertise in all phases of the project including pilot initiation, implementation, training, quality assurance and monitoring implementation and outcomes. The pilot sites are planning to become operational in December 2006.
Co-Occurring Disorders Interagency Committee	The MHD and the Division of Alcohol and Substance Abuse staff the Co-Occurring Disorders Interagency Committee (CODIAC), a committee of providers from mental health, chemical dependency, other cross-systems and consumers. This group has been in existence for approximately 12 years and addresses co-occurring mental illness and substance-related disorders. The two divisions often engage in joint studies and are currently developing a joint demonstration project serving persons with co-occurring disorders in Yakima.
NIMH Planning Grant	The Mental Health Division received a National Institute of Mental Health (NIMH) planning grant in 2003 and was able to create both internal and external work groups to look at issues related to the implementation of evidence-based practices. A subcommittee of MHPAC has been tasked with development of a work plan to guide further efforts.

The work plan includes:

- Disseminating the practices and training providers on their use;
- Identifying barriers to implementation statewide (e.g., funding, licensing, monitoring, and oversight);
- Creating a process for reviewing and selecting new EBPs and promising practices; and
- Hosting a conference highlighting the Committee's work.

As part of MHPAC's activities, an internal work group to coordinate EBP efforts across the MHD (Assertive Community Treatment-ACT, Dialectical Behavioral Therapy-DBT, and family psycho-education), DASA (integrated COD services), Child Welfare (Wraparound and therapeutic foster care services), Juvenile Justice, and the Health and Recovery Services Administration (medication algorithms).

DSHS Juvenile Rehabilitation Administration (JRA)

JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. JRA has long been the provider of last resort for adolescents whose mental health and addiction problems lead to criminal offenses. With a lack of community-based services for youth, JRA provides a variety of efforts both in institutions and at the community level to prevent deeper penetration into the justice system. An early adopter of evidence-based practice, JRA continues to expand its programming efforts. The new JRA Mental Health System Design will establish acute care, extended care, and mainstream mental health treatment units in JRA residential facilities. Their strategic plan also calls on the agency to develop and sustain quality control/adherence standards to assure fidelity to evidence-based treatment modalities and practices delivered with JRA's Integrated Treatment Model (ITM). JRA will maintain a strong continuum of care for juveniles, delivering evidence-based treatment interventions that encourages and facilitates active family involvement, and promotes successful community reintegration. JRA was the first juvenile system to integrate chemical dependency treatment services throughout the continuum, and has specialized services, coordination and management devoted to

	both addiction and mental health problems for youth in their care.
Department of Health (DOH)	The DOH strategic plan contains multiple components toward quality of care, including data and quality assurance management practices. The public health model adopted by the Department relies on epidemiology and scientific research to guide management practices. To assure that public health interventions are designed using the best available evidence, and that Public Health Standards are followed.
Department of Veterans Affairs (WDVA)	All care offered within the War Trauma/PTSD Outpatient Program undergoes several levels of assessment and guidance. The network of providers works to ensure that best practices are employed, and that outcomes meet the expectations of the program. Clients are surveyed in a variety of ways, from customer satisfaction surveys, symptom change assessments, to longitudinal outcome assessment using standardized tools. At all levels from point of referral to time of intake, to the full duration of treatment, clients are informed and offer opportunities to provide input regarding the quality, effectiveness, type, duration, and expectations of treatment. All providers are held to the highest of standards for care, and must pass audits of care and site visits. Quality of care is appraised in several ways, allowing for lowered risk concerns and offering the latest in treatment advances. Frequent training events and conferences allow contractors access to PTSD and other treatment literature and consultation resources.
Office of the Superintendent of Public Instruction (OSPI)	As the lead state educational office, OSPI funds basic education through 243 school districts. A number of coordinated efforts exist locally to provide mental health services. However, there is work remaining to instill the principles of consumer involvement and recovery/resiliency into the educational system. There are two particularly significant developments in Washington State that create opportunities to advance Transformation: Washington Learns, a joint Executive/Legislative body co-chaired by Governor Gregoire and Superintendent Terry Bergeson; and, the newly created Department of Early Learning. Both bodies will be critical to the success of transformation.

Additionally, Chapter 4, *Prevention* describes some of the work required to better understand issues regarding pre-school and school-aged children.

The OSPI five-year strategic plan includes a strategy aligned with the Presidents goal #5: improving collaboration with the Department of Social and Health Services and other child serving agencies to improve access to care for children in school. The OSPI also aligns with this goal in a number of important programs, such as chemical dependency and prevention coordination efforts, and Readiness to Learn, a school based program to improve child well-being.

Transformation Grant Activities

In addition to the activities being pursued as part of the CMHP, Washington State is exploring additional opportunities to address disparities in the mental health services delivery system.

A strategic Research Partnership will bridge the gap between research, policy and practice

Mental health policy development in Washington state has historically been somewhat fragmented. As is typical in a complex public policy arena, little crossover has traditionally existed between the research coming out of the academic community and the policies and practices pursued by policymakers and the service provider community. More often than not, key players have competed, rather than collaborated, for limited funding and innovation opportunities.

The MHTP is working to change that with the creation of the informal Research Advisory Group. On a quarterly basis, the MHTP brings together university researchers and state agencies to talk about the critical needs and how to make the most of the resources available. The Research Advisory Group is designed to provide a forum for discussing practical solutions to real world problems, through the application of science-based research. Researchers are encouraged to collaborate with each other and with state agencies on projects, and strategic partnerships are developed for joint bids on grants and other funding opportunities.

The Research Advisory Group bridges the gulf between scientific research and practical applications by encouraging new collaboration and partnerships across organizations and disciplines, all with the intent of focusing the considerable wealth of knowledge and expertise to develop new empirically

based and tested approaches to mental health services. In Year 2 of the grant, local government, providers, tribes and consumers/families will be invited to participate.

Local law enforcement entities are convening a summit to examine policies and implications of mental health practice

The Washington Association of Sheriff's and Police Chief's (WASPC), with support from the Project, will conduct a policy summit in September of 2006. The agenda for the summit is examining the policy and implications for practice pertaining to consumers in local jails. The Transformation process often identified problems associated with mentally ill individuals held in jails. Local jails are often in the position of responding to and containing consumers in crisis. On most occasions, some criminal activity is involved, but statistics bear out that individuals with mental health problems spend more time in jail than non-mentally ill individuals.

The summit planning group envisions an opportunity to bring policy makers together to discuss solutions. A variety of strategies emerged in the process conducted by the Project, including Crisis Intervention Training for police officers, triage centers and better service relationships between mental health providers and jails. The audience for the summit will be state and local officials in law enforcement, justice and treatment as well as elected officials at both the state and local level. The anticipated outcome of the summit will be a set of policy initiatives to address the issue of mental health and substance abuse services and jails.

Next Steps – Year 2-5 Gap Analysis

Many of the Subcommittees recommendations proposed that new practices be implemented, in some cases to extend existing services, and in some cases to supplant existing services. Many of the practices requested do not meet objective criteria as being "evidence-based," and the EBP Task Group expanded its scope to include a number of practices consistent with subcommittee recommendations.

A review of recommendations from the Subcommittees and the Task Groups and the State strategic plans reveals a wide diversity in approaches. State agencies are planning to ensure that excellent mental health care is delivered and research is accelerated. The review suggests that a great deal of what has been recommended is indeed identifiable in strategic plans. However, many of the recommendations are broad and general, and some of the content of the strategic plans are written without enough specificity to determine the overlap or alternatively, a lack of congruence.

Generally, most of the Transformation recommendations achieve at least some mention in the strategic plans, but it is not clear precisely what is being considered that might address the issues surfaced by subcommittees. Strong congruence is evident in some areas. For example, implementation of evidence-based practices, particularly for children, is evident in both the recommendations and strategic plans. Additionally, the need for accelerated research is also evident. Another strong area of congruence was the emphasis placed on independent Ombuds services for mental health. Although the MHD strategic plan does not provide any specificity as to how it will pursue this goal, the direction is clearly stated, and consistent with the Adult Consumer Subcommittee recommendation. In general, there is greater congruence with regard to children's issues than there is for adult consumer service issues.

These gaps exist in part due to the vagueness of state agency strategic plans. Notable among these are criminal justice interventions. Subcommittees identified broad goals. Task Groups defined specific strategies. Existing strategic plans are non-committal in terms of specific activities to be pursued. The same is true for supporting recovery-oriented, and consumer run services. While clearly identified as desirable goals, some state agencies do not appear to be advocating this approach yet.

Other notable gaps include older adult issues identified by subcommittees and in the co-occurring disorders (COD) goals. The strategic plans of ADSA, DASA and MHD stress activities related to the CODIAC Committee and annual COD conference.

While these efforts are positive steps in the right direction, it is unclear whether the recommendations from the subcommittees and task groups will emanate from the efforts described in the strategic plans.

Strategic plans as currently written are often general, and for the most part, do not reflect much in the way of interagency goals, objectives, and cross systems planning to allow meaningful progress towards the identified subcommittee outcomes to occur. Future planning efforts need to be more specific and concise, and engage multiple agencies working in unison to achieve tangible progress regarding many of the recommendations of the subcommittees.

SECTION 6:

Federal New Freedom Commission Goal #6

Technology Is Used to Access Mental Health Care and Information.

FEDERAL RECOMMENDATIONS

6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
6.2 Develop and implement integrated electronic health record and personal health information systems.

The Transformation Work Group has provided the Task group with guidance and direction to explore technology options

As part of the Transformation Project, the Transformation Work Group (TWG) created the Information Technology (IT) Task Group to develop strategies for transforming the state's mental health system in Washington State.

The objective of the IT Task Group was to develop specific strategies for achieving the TWG's approved outcomes. More specifically, the TWG guided the task group to develop strategies that support linked and/or integrated data across systems. Further, the state will continue to explore ways to make available to individual consumers data from their encounters with multiple providers and make that data available to the consumer's multiple providers and case managers. The goal is to make these data available "on the ground" in "real time." The TWG believes this should be a systemic approach that includes all state systems, and should not be limited to only mental health related systems.

Consumer Privacy will be a paramount concern in system development

Pursuing strategies that would further this concept would necessarily include systems that contain data related to specific individuals, therefore it is even more critical that impacts on consumer privacy and consent be thoroughly addressed. Particular attention should also be given to the relative costs and benefits of each specific strategy.

Consumer input will be a long-term requirement to improving data and technology options

All of the IT strategies will require consumer input and continuing design work. Key issues include:

- Protecting privacy for individual consumers while still facilitating integrated service provision.
- Reviewing contents of websites, screens and reports to be sure they are useful to consumers, providers and managers.
- Reviewing performance measures, outcomes, and evaluation plans: *Are they really measuring what they should?*
- Reviewing websites and reports for accessibility to persons with disabilities, for needed translations, and to be sure that the content is inclusive and respectful.
- Developing vision for continuing directions.

IT Task Group Recommended Strategies

The following strategies were defined by the MHTP IT Task Group in response to Presidential Goal #6.

1. Develop and pilot a consumer-focused, customer driven, recovery focused needs assessment screening tool for mental health and alcohol/drugs that can be used across multiple settings.
2. Develop a website for each consumer that contains an assessment tool and its accompanying recovery goals, which change over time, and can be accessed if consumer gives permission.
    - Expand existing cross-agency outcome database to each consumer receiving public or charity funded health, mental health or alcohol/drug services from any local or state agency, jail, prison or hospital.
    - Include outcomes drawn from public records of important life and recovery issues (such as employments, arrests, graduations, hospitalizations, and marriages).
3. Develop and pilot consistent survey measures for those outcomes that cannot be gathered from existing agency records.
4. Develop and pilot a Smart ID Card and associated Consumer Hub database, and link it to agency databases so they automatically draw demographic and geographic information from the

Consumer Hub.

5. Develop “spaces” on consumer website to record consumer needs and diagnoses centrally and link those spaces to each legacy website to automatically copy fields containing assessments and diagnoses into the consumer website.
6. Develop consumer “spaces” to record shared cases and link those spaces to each legacy system to automatically copy fields containing case manager actions into the consumer website.
7. Develop “spaces” on the consumer website to record prescription medications centrally, and link those spaces to each legacy website to automatically copy fields containing prescriptions, along with dates, into the consumer website.
8. Extend the DSHS Client Services Database tables to all public and charity-funded consumers (persons receiving health, mental health or alcohol/drug services from any local or state agency, jail, prison or hospital). Use monthly or quarterly extracts from each source to add consumers, services, dates and costs (paid and imputed from the encounter data). Verify results with sources.
9. Use the Outcome Database, adjusted for differences between treatment and comparison groups using the assessment and diagnostic information from Strategy 5. Publish reports, whenever possible, that distinguish outcomes by subgroup – demographic, ethnic, geographic.
10. Use the Outcome Database to monitor client outcomes resulting from services received from various MH and AOD treatment providers. Adjust for differences in populations served using the assessment and diagnostic information.
11. Develop quality assurance websites for the providers in each local area, reporting outcomes for different types of consumers.
12. On an ongoing basis, monitor the fidelity to care standards of new and expanding mental health services. Report by provider.
13. Develop a training and quality assurance database on selected evidenced-based practices.

14. Develop a data table comparing service need to service use and service supply over time. Could easily be generated for government funded consumers from the expanded consumer database and the needs assessment database for consumers generated in previous strategies.
    - Use the data table to produce tables and maps for each local area showing the "supply" of providers in relation to the "demand" from the consumer-driven needs assessments ("Supply Rate"). This will allow local communities to decide what "fill in the gap" services might be useful.
    - Use the same table to develop performance measures saying what proportion of consumers "got" the services they needed.
15. Develop the website and define a process for choosing and refining content; develop and update the general content.
16. Develop maps and directories of service providers by specialty area. Include the private providers. Generate lists from licensing databases, expanded 911 lines, crisis and referral databases and other frequently updated directors. Allow providers to self-refer to the lists, with references.
17. Provide on-line training on psychiatric rehabilitation and other topics for families, consumers and others in the community. Track both on-line and in-person usage of that training.
18. Require consumer-run services to enter persons served, frequency and dates of services. Best method might be a website using an ID card, or a web-accessible database.
19. Develop an on-line "registration" form for consumer-run services and groups. Develop a webpage displaying services on the mental health website.
20. Cost out various alternatives for charging services; choose one, and implement it.
21. Be sure that the common screening and assessment tool include the date the service need is identified and application is made.
22. Develop on-line training materials. Make sure they

	are accessible by persons with visual disabilities, and translated into multiple languages. Training materials should include tests of what has been learned as the training progresses. Those tests should be recorded.
Agency and Partner Strategic Directions	The following objectives and supporting activities and measures related to Federal Goal #6 are defined in state agency strategic plans recently submitted to Governor Gregoire.
DSHS, Division of Alcohol and Substance Abuse (DASA)	The DSHS Division of Alcohol and Substance Abuse (DASA) utilizes a variety of web-based applications for data collection and data analysis including conducting research using administrative databases (mental health, Medicaid, employment, criminal justices and others).
DSHS, Health and Recovery Services Administration (HRSA)	The Health and Recovery Services Administration (HRSA) plans to maximize use of technology to take advantage of online services, such as electronic enrollment, eligibility reviews and client communication while safeguarding client privacy. Three specific projects are underway that highlight HRSA's efforts.
Reprocurement Of The Medicaid Management Information System	HRSA has begun the process of re-procuring its legacy Medicaid Management Information System (MMIS), which is currently the main payment system for medical assistance programs as well as other Medicaid-funded services. As envisioned, the new MMIS will assume more payment responsibility within the agency, handling all medical services (both Medicaid and non-Medicaid) as well as those non-medical programs determined to be compatible to MMIS and its new capacities. The MMIS design improvements will also include reporting and decision support capabilities as well as expand into new areas of utilization and accountability, helping DSHS operate more efficiently and effectively than before. In this new role, MMIS will become less of an HRSA system and more of the basic DSHS payer and payment information system.
Outpatient Prospective Payment System (OPPS)	HRSA is modeling the Outpatient Prospective Payment System (OPPS) along the lines of a DRG (Diagnostic Related Groupings) reimbursement structure that would apply to outpatient services. The new system, which will be phased in, will decrease the amount of cost-based payments and replace them with payments based on the actual treatment

and services provided. Because the same methodology is already used by Medicare, the Health Care Authority and Labor & Industries, the new system also offers some consistency to providers.

Emergency Room And Access Research

HRSA has formed a workgroup to begin regular reports and data analyses on provider-access data, including client utilization of Emergency Rooms. Initial reports show that more providers have signed up with HRSA today – refuting rumors of a physician exodus from the program. But other patterns are disturbing – the additional physicians are not keeping pace with the increasing caseload, and Emergency Room utilization is on the increase. Ultimately, this research will provide HRSA with a more efficient grasp of access, give providers guidance on patient-access concerns, and offer clients better health outcomes.

DSHS, Mental Health Division (MHD)

As a result of participation in the 16-state pilot Indicator Project and the 2001 Joint Legislative Audit and Review Committee (JLARC) report, the MHD has moved toward a performance and outcome-based system rather than one that emphasizes process. To prepare for this change, the division, RSNs, and providers spent considerable time updating and revising data reporting requirements and guidelines. The BBA of 1997 has also placed a heavy emphasis on the use of data for management and quality improvement activities.

- Use health technology and telehealth to improve access and coordination of mental health care, especially for consumers in remote areas or in underserved populations.
- Survey the mental health community for current uses of health technology and telehealth.
- Continue to support RSN videoconferencing to enhance consumer and stakeholder meeting capabilities, specialty consultations, and remote site access to care and services.
- Explore financial aspects of telehealth use, and coordinating traditional health and telehealth visits.

Develop and implement integrated electronic health record and personal health information systems**.**

- Survey the mental health community for current

use of electronic health records and personal health information systems.

- Continue to support the implementation of the integrated state hospital information system.
- Continue to support the implementation of a person-centered, integrated, comprehensive electronic health record at all state facilities and community mental health agencies.

DSHS Juvenile Rehabilitation Administration (JRA)

JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. The agencies Client Activity Tracking System (CATS) is a technology supporting effective case management and service provision for youth in their care. The Strategic plan action calls for full implementation of this model.

Department of Health (DOH)

The DOH strategic plan requires use of data to inform the public and design public health programs.

Department of Veterans Affairs (WDVA)

The War Trauma/PTSD Outpatient Program is customer and referral agent accessible from the agency webpage. This site is cross-referenced with many other national and in-state links allowing ease of electronic access. Many veterans and family members find our mental health counseling services through our webpage. Email is used in a HIPAA safe manner to offer information that will lead to information and referral. The webpage offers many informational and educational resources that would assist the treatment seeking veteran or family member find direct information and services, such as all of the WDVA PTSD Program contractors, the federal VA Medical Centers, and all other VA clinics and resources in Washington State. Additionally, other links permit direct access to the world's largest PTSD and war trauma reaction professional library, where a user friendly search offer's solid information about PTSD and other mental health issues. Email traffic within the PTSD Program is monitored daily, even on holidays and weekends, when individuals might be most troubled by their concerns and readjustment needs.

The agency offers a host of other informational resources that would act to help stabilize the life of any veteran and family members. This includes information about benefits and placement of veterans

in one of the WDVA Veterans Homes. Emergency care through the VA Medical Centers can also be found as the customer or referring professional accesses the cross-referenced federal sites. This includes access to federal VA emergency mental health services and hospitalization contact numbers and locations of services.

Transformation Grant Activities

The Transformation Project has funded a project to integrate administration databases from multiple organizations (MHD, DASA, criminal justice and employment). This integrated database will be used for multiple purposes including tracking outcomes. The project has also funded the MHD to improve capabilities of the state to report on the SAMHSA National Outcome Measures (NOMS).

There are several Regional Support Networks who have begun development on electronic health records and project staff are following their progress. The team is also working with a statewide group with representatives from DOC, the courts, local jails, and key legislators to develop electronic health records for those organizations. The TWG has also recommended that Transformation staff follow the progress of the Health Care Authority as they are the Governor's designated lead on developing electronic health records.

Gap Analysis

Although the project is involved with multiple agencies in utilizing technology to document services and track outcomes, little has been done this first year around the telehealth strategies.

Next Steps – Year 2-5

When considering strategies related to integration of data across systems, particular attention should be given to the relative costs and benefits of each specific strategy, and to the impacts on consumer privacy. The TWG requested that the IT Task Group conduct a high-level assessment of their strategies to determine costs, resources, and implementation timelines. The Task Group should focus their assessment on those strategies they believe are the most feasible.

In addition to developing integrated databases for outcome tracking and potentially in cross agency efforts to develop electronic health records, we plan to pursue telehealth strategies in Year 2.

SECTION 7:

Washington State Goal #7

Individuals with mental illnesses have stable housing in the communities where they live.

Washington Believes Stable Housing Opportunities is Critical to Transformation

Washington consumers have identified housing as a key component to successfully managing their mental illness. However, the lack of stable housing, including the lack of support systems to maintain housing, was a key finding in Washington's Resources Inventory and Needs Assessment (See Appendix 2). Consumers also reported problems stemming from the length of time it currently takes for a person to obtain subsidized housing. Reportedly, it can take many months before a person becomes eligible for subsidized housing.

As a result Transformation Project staff asked key informants to provide recommendations for improving stable housing options for consumers.

Subcommittee Recommended Outcomes

The following outcomes were recommended by TWG subcommittees to address housing-related improvements.

Homelessness Subcommittee

1. Housing will be available immediately upon need for individuals/families.
2. Continuation of services after a person has passed the crisis or transitional point (to avoid services and/or housing ending after a person is stable, decompensating back into homelessness).

Key Informant Outcomes

1. People with mental illnesses have stable housing and employment opportunities in the communities where they live.
2. Increased availability/production of affordable housing, with appropriate supporting services for people with mental illnesses, throughout the state.
3. Improved discharge planning from state institutions to eliminate the release of people with mental illnesses without stable housing and supportive services in place.

Task Group Recommended Strategies

The following strategies were recommended by TWG task groups to address housing-related improvements.

Key Informant Strategies

1. Improved linkage of housing, employment, and treatment policies and resources at the state level including integration with mental health legislative initiatives related to state hospital usage and development of community-based alternatives.
2. Provide incentives at the RSN/community/ provider level to promote and fund more supportive housing.
3. Improve data collection to track the housing status of all clients receiving services through DSHS, DOC, DOH, and/or CTED.

Evidence-Based/ Promising/Emerging Practices Task Group

1. Programs are developed for youth and young adults that are developmentally appropriate and meet the unique, individualized needs of this population. Such models should include access to and availability of comprehensive support services including mental health, substance abuse, independent living skills, and vocational training are provided to assist youth and young adults in maintaining housing (Local examples –Youth Care Model, Mockingbird Family Model programs).
2. Establish Housing First: Large investment in development of enough permanent subsidized housing to meet the needs of all homeless people with mental illness. Appropriate supportive services need to be attached to housing.
3. Establish some transitional housing options to provide for overflow need.
4. Make needed mental health and general community support services immediately available to those requiring assistance in process of stabilizing while entitlements are pursued.

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to State Goal #7 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Division of Alcohol and Substance Abuse (DASA)

The DSHS Division of Alcohol and Substance Abuse (DASA) funds and/or supports a variety of housing programs such as the Oxford House and other transitional housing. This includes specialized housing for men, women, and pregnant or parenting women. DASA also works with local government and providers to team up with housing organizations to increase the types of housing available to chemically dependent individuals.

DSHS, Mental Health Division (MHD)

The DSHS, Mental Health Division is the contracting agent for local-level services provided through RSNs. With regard to residential and housing services, Chapter 71.24 RCW requires that RSNs ensure:

- Active promotion of access to and choice in safe and affordable independent housing that is appropriate to the consumer's age, culture, and residential needs.
- Provision of services to families of eligible people who are homeless or at imminent risk of becoming homeless, as defined in Public Law 100-77, through outreach, engagement, and coordination or linkage of services with shelter and housing.
- The availability of community support services, with an emphasis on supporting consumers in their own home or where they live in the community, with residences and residential supports prescribed in the consumer's treatment plan. This includes a full range of residential services as required in Chapter 71.24 RCW.

Department of Community, Trade, and Economic Development (CTED)

CTED provides a variety of programs focused mostly on community development activities, but including housing and employment supports. The community mobilization program supports communities in preventing the impacts of substance abuse. In addition they provide mental health services through the Crime Victims program. CTED's strategic plan identifies an important strategic initiative: *Interagency coordination of homeless programs to support effective provision of housing*. A goal of this initiative is to improve the lives of homeless

	individuals and maximize resources by providing increased coordination and reducing the fragmentation of housing services. In 2006 the state created the Interagency Council on Homelessness in response to the 2005 legislative requirement to reduce homelessness in Washington State by 50%.
Department of Corrections (DOC)	DOC will assist offenders in connecting with housing services.
Department of Veterans Affairs (WDVA)	WDVA has for many years offered homeless outreach to troubled veterans and families. This has taken many forms and has worked with target populations to include rural, urban, and women veterans. Joblessness has also been the focus on other subprograms. In all cases the mental health status of each individual has been the concern when placements are accomplished. The War Trauma/ PTSD Program has long worked with those who are homeless, or who have a high potential for homelessness. Forty percent of homeless are thought to be veterans, and a very high percentage of this group also suffers significant mental health related problems. WDVA is working to create a specialized program that will house, treat, and train homeless veterans within the next year. In conjunction with the federal VA, these services will act to address to a greater degree the needs of this population
Transformation Grant Activities	As part of the transformation process, Washington State is exploring additional opportunities to expand stable housing for consumers and their families. For example, Transformation Grant staff are collaborating with other Washington stakeholders to end homelessness and create employment opportunities for individuals who are homeless and also experiencing mental illness. These initiatives include "Taking Health Care Home" which is located in King County and administered by the City of Seattle, in collaboration with the Divisions of Vocational Rehabilitation and Developmental Disabilities, providers, RSNs, members of the private sector such as developers, and other key housing and employment stakeholders.
Gap Analysis	Housing issues are intimately tied to issues of employment. Efforts to create jobs for consumers, as well as families and youth, both within the existing service delivery system and complementary to it, cannot succeed without the recognition of this

relationship. In addition, implementation of the CMHP outcomes and strategies will require that non-traditional partners (e.g., ESD, CTED) become engaged throughout the process and coordination efforts be expanded. This coordination should focus on increasing efforts to reduce stigma for individuals with mental illness who seek both housing and employment as part of their recovery. This effort will also be coordinated with the MHTP's Social Marketing Campaign and Workforce Development initiatives.

While many state agencies have identified housing as an area in need of policy attention, additional cross-agency coordination is needed to identify specific projects for future implementation.

Next Steps – Year 2-5

Many counties are developing strategies to end homelessness in ten years. This is a national movement. The Transformation Project has been in contact with several statewide homelessness and housing committees and will work toward creating collaborative strategies in Year 2.

SECTION 8:

Washington State Goal #8

Employment is an expectation and a priority in Washington for people with mental illness.

Washington Believes Improving Employment Opportunities and Outcomes is Critical to Transformation

Key findings from Washington's Resources Inventory And Needs Assessment (see Appendix 2) clearly articulate several consumer concerns regarding opportunities for consumers to obtain and sustain employment.

- Most consumers do not believe that mental health services help them get basic resources such as employment and safe housing – services are not seen as helping them gain independence.
- Almost half of the respondents reported they are seldom, rarely or never supported in getting the education and guidance they and their families need to be fully supported.
- Most respondents (57%) reported that they have never been helped by mental health services to get or keep employment.
- Only 13% of all respondents reported being employed.

As a result, the Transformation Project staff asked key informants to provide recommendations for improving employment opportunities and outcomes. These individuals developed their recommendations based two guiding principles:

1. We believe in the value of work at the earliest stages of recovery, as an aid to the recovery process.
2. We recognize that employment can help people develop motivation to change, promote dignity and self-respect, and instill hope for the future.

Subcommittee Recommended Outcomes

The following outcomes were recommended to address employment-related improvements. A complete list of strategies and outcomes is included in Appendix 3.

Adult Consumers and Families Subcommittee

1. Consumers have access to evidence-based vocational rehabilitation services on demand that include high quality, supported employment based on national standards. These programs work collaboratively with Division of Vocational Rehabilitation (DVR) to ensure employment for as many consumers as possible.

Key Informant Outcomes

1. People with mental illness are successful in getting and keeping employment in the community where they live.
2. Increased availability of targeted employment-related resources, supports and services for people with mental illness throughout the state

Task Group Recommended Strategies

The following strategies were recommended by the task groups to address employment-related improvements.

Key Informant Strategies

1. Improved linkage of employment policies and resources at the state level with the Mental Health Division and the Division of Vocational Rehabilitation jointly responsible for alignment, leveraging and accountability.
2. Incentives at the RSN/community/provider level to promote and fund supported employment as an evidence-based practice.
3. Improved data collection to track the employment outcomes for mental health customers who utilize DVR, Clubhouses, WorkSource and other employment related resources.
4. The Mental Health Division, Division of Vocational Rehabilitation, RSNs, and Consumer Organizations will jointly sponsor statewide and local working groups comprised of a majority of employers to identify/implement specific strategies and activities that result in increased employment opportunities for consumers.
5. Increase employment activities.

6. RSNs and Community Mental Health Professionals will deliver therapeutic services that increase a consumer's resiliency in a work setting and supports the individual in getting and keeping a job, based on a model that recognizes employment as an essential element of recovery.
7. Community Mental Health Services will include specific activities that enable consumers to maintain long term stability on the job, including activities that assist employers in supporting consumers on their jobs.

Evidence-Based/ Promising/Emerging Practices Task Group

1. The MHD will pilot two self-directed care programs, one in Eastern Washington and one in Western Washington, based on the Florida SDC Model.
    - Consumers in this program will be paired with a trained life coach who will act as a brokerage support to assist in the overall design and management of their self-directed care plans.
    - Consumers in this program will be eligible to purchase services for the purpose of accessing:
        - Supported Employment.
    - Recovery support services (services that are alternative to traditional mental health services) such as:
        - Services related to developing employability and/or productivity that will lead to employability.
2. Use individual placement and support.
3. Use assertive community treatment with employment component.
4. Provide supported employment and clubhouse-based transitional employment.
5. Use peer support, WRAP, clubhouse, and supported education as a way to maintain recovery and retain employment.
6. Cross train vocational rehabilitation staff and clinical and vocational mental health staff to increase integration and communication.

7. Provide support for consumer-owned and operated businesses.

Agency and Partner Strategic Directions

The following objectives and supporting activities and measures related to State Goal #8 are defined in state agency strategic plans recently submitted to Governor Gregoire.

DSHS, Aging and Disability Services Administration (ADSA)

ADSA plans to implement the Working Age Adult policy for developmental disability clients. This policy relates to providing eligible clients with employment programs, clients with co-occurring mental illness.

DSHS, Division of Vocational Rehabilitation (DVR)

DVR will adopt methods, rules and polices that create equitable access to services for individuals with all types of disabilities.

DVR will develop counselor skills serve individuals with the most significant barriers to employment. They will modify service provider contracts to allow more flexible, outcome-based and cost effective services. DVR will work with the Mental Health Division (MHD) to develop a supported employment program as well as a strategy for sustaining clubhouse models.

DSHS, Division of Alcohol and Substance Abuse (DASA)

DASA encourages strong connections between providers, vocational employment organizations and local government in order to improve client employment outcomes. A collaborative effort between local Temporary Assistance for Needy Families (TANF) offices and the chemical dependency systems has resulted in the co-location of counselors in the TANF office to screen clients and refer to treatment as needed so that their dependency is not a barrier to obtaining or sustaining employment. DASA also monitors employment outcomes of all treatment clients utilizing administrative databases.

DSHS, Mental Health Division (MHD)

RSNs and PIHPs coordinate with rehabilitation and employment services to assure that consumers wanting to work are provided with employment services; to assist consumers to achieve the goals stated in his/her individualized service plan; and to provide access to employment opportunities, including:

- A vocational assessment of work history, skills, training, education, and personal career goals;
- Information about how employment will affect

income and benefits the consumer is receiving because of their disability;

- Active involvement with consumers served in creating and revising individualized job and career development plans;
- Assistance in locating employment opportunities consistent with the consumer's skills, goals, and interests;
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required; and
- Interaction with the consumer's employer to support stable employment and advise about reasonable accommodation in keeping with the Americans with Disabilities Act (ADA) of 1990, and the Washington State Anti-Discrimination Law.

The Mental Health Division is a primary party to the Medicaid Infrastructure Grant that has a focus on consumer recovery, and has included the following actions, accounted for in annual reports to the public and to the MHPAC:

- Numerous trainings statewide on Healthcare for Workers with Disabilities and Ticket to Work;
- Seven “Pathways to Employment” conferences held throughout the state which provide information on employment-related programs, housing, transportation, social security benefits and other information related to recovery;
- Employment track offered at the annual Behavioral Health Conference held each June;
- Twenty conference scholarships awarded to consumers involved with employment-related programs;
- Ongoing collaboration with other DSHS partners in order to increase the infrastructure of employment-related supports for persons with disabilities;
- Membership on the advisory board for the Center for Continuing Education on Rehabilitation;
- Continued funding expected for one FTE in 2005;

	and • Continued funding is expected to initiate an Enhanced Peer Support Training module, offered in addition to the 40-hour required training for certification.
DSHS Juvenile Rehabilitation Administration (JRA)	JRA is responsible for juvenile institutions, group homes and local parole. JRA also funds county juvenile court and detention services. JRA strategic planning calls for expanding and strengthening education and vocational programs throughout the juvenile systems continuum of care.
Department of Community, Trade, and Economic Development (CTED)	CTED provides a variety of programs focused mostly on community development activities, but including housing and employment supports. The community mobilization program supports communities in preventing the impacts of substance abuse. In addition they provide mental health services through the Crime Victims program. Through local economic development councils, CTED is responsible for linking WorkFirst clients to employment opportunities. CTED recognizes the need to serve disabled and vulnerable populations; however, it remains unclear if mentally ill individuals are effectively identified for supported services in locating and keeping employment through this program.
Department of Corrections (DOC)	DOC will assist offenders in connecting with employment services.
Employment Security Department (ESD)	ESD will develop processes and methods to identify individuals who need WorkSource assistance most and increase job placement services to them. This includes individuals with disabilities who lack the education or training to compete for good jobs. To accomplish this task, the Transformation Project staff will need to work with ESD as they improve their assessment process to identify persons who have mental illness and require additional support services in order to become employed.
Department of Veterans Affairs (WDVA)	WDVA is working to create a residential transitional program currently being planned to open on the Retsil Veteran Home campus next year. This unique program will train and place disabled veterans in jobs, while also helping them return to community life. This program borrows from successful models that have worked with similar populations by

creating stability, consistency, safety, and sufficient time and treatment/support, to endure attempts to resume participation in gainful employment. The federal VA is a partner in this new program, one that will offer great hope for our troubled war veterans.

WDVA also offers a program that resulted from recent state legislature efforts. This specific effort is aimed at helping war disabled veterans return to active connections within the world of work. The Veteran Conservation Corps (VCC) has already created dozens of opportunities for disabled veterans, particularly those with war-related Post Traumatic Stress Disorder (PTSD), to work within their community on wildlife projects, most notably, salmon habitat restoration. Guided by an experienced contract wildlife biologist and former PTSD treatment provider, veterans are placed in stream, estuary, and coastal tideland restoration activities that are designed to allow the veteran to participate constructively in the work of restoring salmon runs and related critical environments. Over the next few months these activities will be enhanced when six placement coordinators situated around the state begin placing veterans into restoration work sites. Connections with various state and federal agencies, private funding resources, and organizations dedicated to restoration efforts, is allowing previously fully disabled and socially disconnected veterans an opportunity to return to healthy occupational experiences. For many of these very traumatized warriors, this is often the first time they have been able to offer something to their communities and at the same time see the products of their efforts. The results their hard work, often stands in direct contrast to what these veteran might believe and remember about the combatant lives. Performing in this way, allows for a renewal of who they are and their potential for benefit to the community.

Transformation Grant Activities	As part of the transformation process, Washington State is exploring additional opportunities to expand employment related activities for consumers.
Gap Analysis	While many state agencies have identified stable employment as necessary for an individual to achieve recovery, few of these agencies have delineated clear strategies for accomplishing this. As mentioned in Goal #7, all effort to increase employment opportunities will be coordinated with our partners to ensure that activities related to both housing and employment are considered together.
Next Steps – Year 2-5	The MHTP Project is already engaged in crafting a Workforce Development Plan aimed at both expanding the current mental health workforce in alignment with SAMHSA's efforts (as laid out in the DRAFT National Action Plan developed by the Annapolis Coalition) and expanding the number of consumers, family members and youth employed in delivering mental health services in Washington. In Year 2, we will facilitate cross-agency discussions in an effort to develop more specific recommendations and strategies regarding employment services.

CHAPTER 2:

GOVERNANCE AND ORGANIZATIONAL STRUCTURE

LEADERSHIP AND GOVERNANCE IN MENTAL HEALTH POLICY IS BROAD-BASED

In Washington State, a broad consensus has developed among the mental health community stakeholders about the need to transform the mental health system. At the state level, both the legislative and executive branches have demonstrated a firm and lasting commitment to this effort.

Legislative Commitment: In 2004, the legislature established the Joint Legislative and Executive Task Force on Mental Health Services and Financing, a body that has significantly influenced the direction of change. Based on recommendations of the Task Force, the legislature acted promptly by appropriating monies to fill a critical funding gap, and adopted legislation that has modified state policy related to the provision of mental health service and gave the state's lead agency increased authority (accompanied by the expectation of increased accountability).

In addition, this body prompted the state Department of Social and Health Services to submit a proposal for the Mental Health Transformation Grant, a move that was strongly endorsed by the Governor.

Executive Branch Commitment: Governor Gregoire not only supported the Task Force's recommendation to pursue the transformation grant but also demonstrated the strength of her leadership in this arena by establishing the Partnerships in Recovery Initiative to provide an organizational framework for pursing mental health transformation in Washington State.

Key agencies and community organizations (including tribal/state/local government, providers, consumers, families, mental health planning advisory council and law enforcement) are also supporting the transformation process by committing leadership and resources to the transformation process. A goal of the Transformation Grant is that leaders from key organizations will partner together to develop the future direction of mental health in the state of Washington. These collaborations are occurring and will continue to be facilitated and supported by the MHTP staff.

FORMAL TRANSFORMATION GOVERNANCE

Since the award of the Transformation Grant to Washington, as one of seven demonstration states, a more formal governance structure has been established. (Exhibit 2 illustrates the governance and organization structure for the project.) This, too, is broad-based and draws on leadership from a variety of mental health venues, advocates, and allied fields throughout the state. Governor Gregoire continues to assert her leadership role, and has established the Mental Health Transformation Project team within her office. By making the transformation office an arm of the Governor's Office rather than delegating the work to a state agency, the project achieves a high level of visibility and status necessary and appropriate to the task at hand. This placement also signals to all partners that this is an inclusive process that crosses agency, government, and geographic borders.

Transformation Work Group (TWG)

The MHTP is guided by the executive-level Transformation Work Group (TWG.) The TWG is comprised of 32 members, including state agency directors, tribal representatives, leaders of local government agencies and community organizations, provider associations, consumer/family organizations including youth, The Mental Health Planning and Advisory Council and law enforcement. This body is charged with establishing the vision for transformation of mental health services in Washington State, preparing the CMHP, and providing strategic direction and oversight to the transformation process. The Transformation Project Executive Director chairs the TWG.

Organizational Structure

As noted above, the TWG is supported by the MHTP team in the Office of the Governor. This small, professional staff provides staff support, community outreach and facilitation, research, analysis and other services to the TWG and to its various supporting subgroups. Team members bring a variety of skill sets to the project. Several members of the team are consumers who are charged with ensuring the consumer perspective is considered at every step of the project.

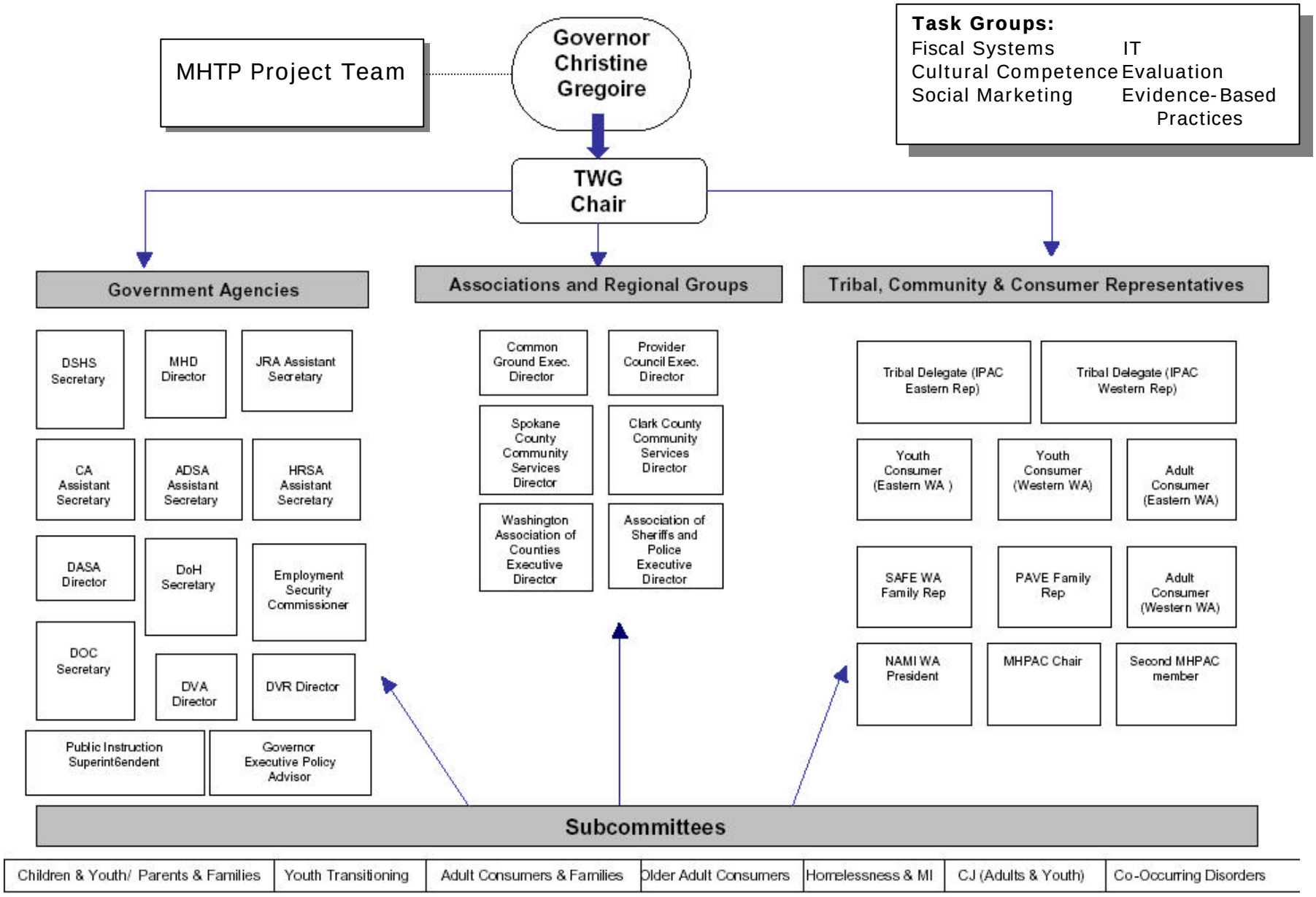


Exhibit 2:
MHTP Organization Structure

Subcommittees identified the priority outcomes a transformed system should be designed to achieve

The TWG established two sets of advisory teams to help guide its efforts. Subcommittees – comprised of consumers and family representatives, local, state and other community agencies – were appointed to gather public input on strengths and weaknesses of the current system and, more importantly, to define what a transformed system should look like. The subcommittees were charged with identifying what outcomes a transformed system should be designed to achieve. Subcommittee membership included at least 51% Consumers and family members to ensure their work reflected the consumer voice and focus.

Task Groups identified strategies for achieving those priority outcomes

The TWG was also advised by task groups, comprised of knowledgeable experts (including agency staff, clinicians and service providers, researchers, and consumer representatives). The task groups were asked to identify specific strategies that could be used to achieve the identified outcomes.

In Year 2, TWG and the MHTP shift to facilitating and supporting partner agencies

The outcomes and strategies presented to the TWG provide the direction and form the vision underlying this CMHP. The responsibility of converting these visionary action plans into reality rests with the transformation partners. The TWG and the MHTP project staff will be working in Year 2 and beyond to facilitate and support participating agencies in their efforts to translate the vision into concrete actions.

Integrating Transformation with the Mental Health Planning and Advisory Committee

The Mental Health Block Grant Planning and Advisory Council (MHPAC) is a key participant on the TWG and in the Transformation Grant process. In addition, two Transformation staff members sit on MHPAC and MHPAC members have been involved with the subcommittees and task groups established in year one of the grant. Also, MHPAC sits on the Community Transformation Partnership (CTP), a group of consumer/family organizations that the Transformation Project is helping to develop its structure and direction.

Interrelationships between Transformation and the state's Mental Health Block Grant

We do not yet have clarity on the interrelationships of the Block Grant and the Comprehensive Mental Health Plan. This discussion will begin as soon as we submit our first year plan.

CHAPTER 3:

MENTAL HEALTH TRANSFORMATION IN INDIAN COUNTRY

INTRODUCTION

Washington State has worked towards developing consistent relationships with the Tribal governments within our state. The Centennial Accord affirms the government-to-government relationship between the state and Tribes. In keeping with those expectations, the MHTP developed a parallel process for providing Tribal input, tribal outcomes and strategies contained in this chapter, with the support of the American Indian Health Commission, the DSHS Indian Policy Advisory Committee, and through contract with the Northwest Portland Area Indian Health Board (NPAIHB).

Two public forums were conducted in May 2006. NPAIHB conducted a thematic analysis of the information received during those events. Each item identified showed the number of times it was raised as an issue in the meetings (the number in parenthesis before each stated theme). In July, the Indian Policy Advisory Committee (IPAC), a function of the Department of Social and Health Services with Tribal leader membership, reviewed and organized the themes from the two public forums into two major outcomes and specific, recommended strategies for reaching those outcomes. The report appears here in its entirety: the TWG has received the recommendations and they are currently under review.

TRIBAL FORUM REPORT[1]

Overall Outcome: In accordance with the principles of the Centennial Accord, the Mental Health Transformation Grant activities will be developed and measured with a commitment to the Government-to-Government relationship of the Governor's Office and the Federally Recognized Tribes of Washington State. Participation and inclusion in all facets of the development of the transformation plan and implementation will acknowledge this relationship, and seek mutual opportunities to address the mental health needs of the Native American Communities.

(Topics are listed in order of number of responses per Issue.)

[1] Report for the Northwest Portland Area Indian Health Board, Mental Health Transformation Grant, State of Washington. Linda D. Bane Frizzell, Ph.D.

1. Issue: *(45)*

There needs to be intensive efforts developed to address cultural competency issues and problems.

Outcome: There will be an improved understanding by State officials/employees and other local governments about tribal government legal status.

– There will be tribal legal status training for non-tribal providers, local governments, and State employees.

Outcome: There will be an increase in culturally competent mental health service providers.

– Cultural or traditional services will be viewed as an equal service when compared to western/European mental health practices; and will be equitably reimbursed and recognized as legitimate services.

Outcome: There will be an increase in culturally competent mental health service programs.

– There will be an increase in research activities, with tribal government approval, to increase the body of knowledge (best practices) for Indian specific programs.

2. Issue: *(34)*

There should be regular meaningful tribal consultation meetings established (annually, or biannually, or quarterly) to work with tribal representatives at the government to government level for: discussion of health issues, policy development, collaborations, seamless operations, assessment and evaluation of programs.

Outcome: Treaty and Executive Order Tribal rights will be honored.

– Consultation meetings will be meaningful, with each government contributing, and with representatives that have "administrative authority" to make decisions about: health issues, communication, waivers, policy development collaborations, seamless operations, assessment and evaluation of programs.

Outcome: There will be tribal representation on the State's Mental Health Planning and Advisory Council, Ethnic Minority Advisory Committee, and Transformation Grant's committees.

- There will be a process developed to ensure tribal representation on all respective commissions, planning committees, and other groups established that would have an impact on tribal populations.

3. Issue: *(33)*

Mental Illness and co-occurring disorders are difficult to segregate (as is currently true in the current State system; but not in most tribal behavioral health programs) when the focus should be on the patient/client as a whole person who must be able to interact with multiple entities in their communities.

Outcome: There will be comprehensives services that are delivered in a seamless system.

– There will be Community Mental Health Centers developed to promote the seamless delivery of services.

– There will be a system developed to share HIPAA and provider approved medical record transactions that will be non-duplicative for tribal providers.

– Patients/clients will not be required to complete multiple eligibility forms or endure repetitive tests/assessments.

4. Issue: *(26)*

The RSN system has not proved to be effective, accessible, or culturally competent for use by American Indian patients nor has there been effective participation with tribal providers.

Outcome: The State must acknowledge that it has a shared responsibility with the federal government to provide health services. This responsibility should not be delegated to RSNs, municipalities or other governmental entities.

– The State, in consultation with tribal governments will develop a reimbursement system that is direct and responsive to meet the needs of patient/client. This system will provide reimbursement for all tribal behavioral health services and is not solely dependent on any single payer (e.g. public, private, other third party payers).

5. Issue: *(21)*

License/certification criteria needs to be changed to deem tribally certified professionals and facilities as eligible to be

reimbursed for services, including where desired, direct State contracts.

Outcome: There will be an acknowledgement by certification bodies and payers of services to accept practices of cultural customs and traditional health practices by tribally certified providers and facilities.

– Tribal governments will maintain records and certificates of their certified personnel and facilities.

– There will be certification programs developed to allow for acceptance of training in related disciplines to be applied toward a generalist certification.

– There will be certification programs developed to include recent advances in behavioral health services (i.e. peer counseling, motivational interviewing).

6. Issue: *(16)*

The law enforcement workforce and the court system need to be changed to adequately protect communities and become a collaborator in the mental illness service delivery system.

Outcome: There will be an increase in the overall number of law enforcement professionals, and an increase in capacity for improving outcomes for people who are mentally ill.

– Law enforcement professionals will be trained in interventions that include: coordination procedures with mental health professionals, crisis intervention, dealing with people with mental illnesses (including patient confidentiality), and cultural competence.

Outcome: The State and local governments will recognize tribal court orders with full faith and credit and accept tribal assessments.

7. Issue: *(15)*

The state Medicaid plan needs to be changed to include more reimbursable services for prevention and for patients with mental illness and co-occurring disorders. Current programs are over burdened and consequently do not have the ability to cost-shift expenses to maintain programs and services without reimbursement.

Outcome: The state Medicaid plan will be enhanced to include more reimbursable services for prevention and for patients with mental illness and co-occurring disorders.

8. Issue: *(5)*

There is not enough emphasis on the impact of the K-12 educational system and its role in mental health. This relates to the issues associated with school personnel to respond to mental health issues and administrative issues on how they operate educational programs.

Outcome: There will be increased support for the educational system to develop programs to increase their ability to deal with mental health issues, including allowance for the increasing numbers of drug abuse affected children.

- Public K-12 schools will enhance their prevention curriculums and on-site health services.
- The State will invite Tribal Colleges to become more involved in addressing the mental health needs including curriculum development, cultural competency training, research projects, and professional preparation (certification).

9. Issue: *(4)*

Resources need to be allocated to enable system changes needed to participate in the transformation project.

Outcome: There will be a commitment by the State to begin a process that brings together tribal service providers, higher education, Portland Area Indian Health Board, SAMSHA (including the Center for Substance Abuse Prevention and the Center for Substance Abuse Treatment), and other collaborators.

- This commitment will be progress toward improving the lives of Indian people and not just another pilot project that gets buried in the bureaucracy.

NEXT STEPS

Recommendations in this section have not yet been reviewed by the TWG. This will occur at the August 25, 2006, meeting.

CHAPTER 4:

PREVENTION

TRANSFORMATION PROJECT PREVENTION ADVISORY GROUP

Throughout the process of collecting public input, and engaging policy leaders in discussion, the concept of a true mental *health* system continuously emerged. Both consumers and state executives put it succinctly: "We don't have a mental health system; we have a mental illness system." The sentiment was echoed as the TWG grappled with the core values and the shift in thinking required to truly realize Transformation. Prevention always challenges state executives and policy makers. Prevention requires significant levels of resource and patience while waiting years or even decades for results. However, the evidence is clear; prevention pays. The state envisions a clear approach incorporating and coordinating prevention activities in a broad, public health model. Rather than developing a "mental illness prevention" strategy, the Project recommends a single, well-articulated statewide prevention policy with a healthy Washington as a centerpiece strategy.

Mental Health is incorporated into existing prevention and early intervention initiatives and more coordination occurs among these programs. Washington State Comprehensive Mental Health Plan – *Transformation Theme #2*

Prevention is a fundamental component of a comprehensive mental health system. As is typical in many states, however, Washington's current prevention efforts are fragmented and lack coordination. Further funding of prevention-related activities represent only a small percentage of overall mental health funding, if any at all. Most existing programs are targeted to discrete populations, despite the fact that most risk factors cut across multiple demographics.

The state does have at least three mature and stable prevention programs. For example, the Division of Alcohol and Substance Abuse has a well-developed and successful substance abuse prevention approach, with cross-cutting services at the state level, and close coordination with service providers at the local level. (DASA services are discussed in more detail below.) Also, the Family Policy Council, a multi-agency advisory board with both executive and legislative membership has provided sound state and local level policy direction related to prevention activities for several years. The Department of Community, Trade and Economic Development also has the Community Mobilization program that funds small projects statewide. Other prevention activities, however, are small, under-funded and disconnected from a broader prevention approach. As a result, prevention services are fragmented.

The Prevention Advisory Group has been convened to provide recommendations for overcoming this systemic fragmentation. The Advisory Group is tasked with developing cross-discipline partnerships across the state, and among organizations that share an interest and expertise in Prevention. Initially, the focus of the group is to provide a forum for discussing emerging research and to move the mental health field forward in its advancement of prevention efforts. Ultimately, however, the goal is to empower this group to develop a set of strategies for elevating the importance placed on prevention services, to inform prevention policy development, and to encourage a more cohesive system of prevention services in Washington.

The Prevention Advisory Group members are multi-disciplinary and geographically diverse. MHTP initially invited individuals representing state agencies and university researchers focusing on prevention, encouraging those initial members to reach out to others in the field and extend the opportunity to participate. Thirty-six individuals now serve on the group with interests and expertise ranging from prevention policy to early childhood learning. Other expertise on the group include: infant mental health; maternal/child health; early learning; child abuse and neglect; juvenile justice; substance abuse; health policy; epidemiology; nursing; and, medicine. Appendix 5 contains a list of current group members.

Most Advisory Group members are well versed in the public health approach to prevention; the model most often used in developing programs and demonstration projects in Washington. This focus on the public health model is enhanced by having the co-founders of the Social Research Development Group (SRDG), affiliated with the University of Washington as invited members of the advisory group. The SRDG is noteworthy for its role in advancing the risk and protective factor approach to prevention.

The current focus is on the most seriously ill, reducing the ability to respond to early intervention opportunities

The Prevention Advisory Group also explored strategic areas where a more focused prevention effort might have the greatest impact. Although the TWG task groups did include screening and early intervention strategies that could correctly be defined as preventative for *individuals*, strategies targeted to *community and family* were noticeably absent. The group examined the federal National Outcomes Measures for mental health and agreed to begin considering additional, prevention-oriented outcomes.

The Advisory Group recognized the need to more carefully define prevention. The Group agreed to focus on five specific areas in its planning work for the first year: 1. Infant mental health; 2. Pre-school and elementary school children and their families; 3. Late-adolescent/young adult mental health; 4. Preventing hospital re-entry; and, 5. Preventing mental health problems in older adults.

Infant Mental Health

The University of Washington's Center on Infant Mental Health and Development is the leading state resource for advancing training, research and policy in Infant Mental Health. Their primary focus is on prevention and intervention with high-risk groups such as families in poverty, teenage mothers, families struggling with post-partum depression, and families at risk for child abuse and neglect. Currently, there is a lack of research on treatment which makes implementing evidence based treatments difficult. Therefore, their Birth to Three Lab is translating current research into treatment models and conducting clinical research to develop evidence-based practice in infant mental health. Policy and training efforts are being developed with a wide range of stakeholders including pre-professional students, child care providers, policy makers, educators, primary care providers, child welfare personnel, legal personnel, early intervention providers and mental health providers. The aim is to embed infant mental health principles and an understanding of relationship-based approaches in all of the systems in which we serve infants, toddlers, preschoolers and their families.

Pre-school and Elementary School Children and their Families

The State is currently undergoing a significant structural change in the provision of early childhood services by creating a new Department of Early Learning. Knowledge and experience with Headstart and the Early Childhood Education and Assistance Program (ECEAP), a state funded equivalent to Headstart, has produced expertise for the state that contributes to our thinking about prevention of serious mental health disturbances in children. While excellent work occurs in pre-school education programs, issues around screening and early intervention for children in public schools remains a challenge. Services to the parents are also limited and even those who have children with the most severe mental illness report that services are woefully inadequate. The activities to promote early learning in the state of Washington have been accelerated by a Council on Early Learning appointed in November, 2005. Recommendations of the Council on Early learning resulted in the creation of the cabinet-level Department of Early Learning in July 2006.

In addition, a private/public partnership "Thrive by Five" has been established between the state and the philanthropic community in Washington. This partnership has produced combined funding of $9 million new dollars to be invested in promising approaches to promoting early learning in the state. The areas of childcare and parent support are the two foci of the activities. Mental health has been a part of the effort with the emphasis in the early learning plan being on the social emotional development of the young child. The Gates Foundation is planning two demonstration sites for providing services to families and young children. One site will be in the Seattle area in Western Washington and one will be in Eastern Washington.

The Department of Health, Office of Maternal and Child Health (OMCH) is involved in several activities related to the prevention of social, emotional, behavior and mental health problems. One of these activities is to coordinate MHT planning efforts with other planning and system change initiatives that OMCH is involved with, including:

– Early Childhood Comprehensive Systems (ECCS) Grant – A federal grant from the Maternal and Child Health Bureau to promote comprehensive systems for children birth to kindergarten entry. One of the required focus areas is Social, Emotional and Mental Health. In Washington State ECCS is part of Kids Matter. Kids Matter is a partnership between DOH (ECCS), the Governor's Head Start-State Collaboration Office (Department of Early Learning) and the BUILD Initiative, a national child care quality improvement initiative (the Washington lead is the Foundation for Early Learning). A framework has been developed and its implementation is under way. For additional information, see www.earlylearning.org/kids-matter.

– Washington State Partnerships for Youth (WSPY) – OMCH convenes this broad stakeholder group that is developing a statewide adolescent health plan, including mental health. For more information see the WSPY website: www.son.washington.edu/wspy/

– Coordinated School Health – The DOH Office of Health Promotion coordinates with the Office of the Superintendent of Public Instruction in the implementation of a federal grant from the Centers for Disease Control and Prevention. Grant activities include systems planning and infrastructure building for comprehensive school health, including social emotional and mental health.

– Youth Suicide Prevention Plan - DOH works to implement the Washington State Youth Suicide Prevention Plan through the Youth Suicide Prevention Program (YSPP). YSPP focuses on increasing knowledge, addressing beliefs about suicide, and building skills in people to seek help for themselves or youth they come in contact with. The plan and other information is available on the YSSP website: www.yspp.org/aboutYSPP/reports/Wa_plan.pdf

Late-Adolescent / Young Adult Mental Health

During the work of the Social Marketing effort, a literature review noted the demographics of first onset of serious mental illness to be between the ages of 18 and 31. The Prevention group is interested in looking at the research on early identification and intervention within this age population. Are there opportunities to identify risks in this population? Do social and

emotional disturbances in younger children predict onset of serious mental illness? Do epidemiology efforts to date inform us about individual, family and/or community risks? Are there strategies at a family or community level that might reduce the incidence of onset? What service systems connect with this population at the earliest point in the progression of mental health problems? Do first admission patients in mental health hospitals share risks? The group recognizes that there may be research available that will guide the development of policies and strategies for this target group.

Preventing Hospital Re-entry

Many of the strategies developed in this plan focus on the services needed by consumers to recover and live productive lives. These strategies can be viewed as preventative, in that they represent efforts to promote health, independence, and personal recovery. The advisory group, specifically, is interested in a prevention model for assisting community services that support individuals wishing to remain in recovery (similar to the work around relapse prevention for persons with addictive disease.) Relapse prevention has achieved significant credible results in assisting individuals and their support systems to recognizing and anticipating risks that lead to relapse. Further examination of the triggers for mental illness episodes and strategies to use when those triggers are recognized can contribute significantly to maintaining recovery.

Preventing Mental Health Problems in Older Adults

Aging adults face significant life changes. Both physical and mental health problems can increase morbidity and lower quality of life. The advisory group is interested in looking at factors that contribute to increased levels of depression and serious mental illness such as the community environment (e.g., isolation); chronic health problems and trauma (in the form of loss of friends and family members); and co-occurring disorders. The advisory group is also looking at substance use disorders among older adults. The group will examine strategies and practices available to reduce onset of serious emotional disturbances and co-occurring disorders.

Additional Prevention Activities

Beyond the work of the Mental Health Transformation Prevention Advisory Group, two additional MHTP efforts are notable. In Washington State, the Washington Health Foundation (WHF) is a non-profit organization promoting health policy. Recently, the WHF began a policy initiative: Healthiest State in the Nation Campaign. For 2007, their state policy priorities (still in draft) include mental health. The organization pursues a public health/wellness agenda. The draft policy focus is framed as "strong mind, strong body, strong spirit. It includes mental health, dental health and physical fitness"; effectively addressing the President's New Freedom Commission Goal #1. The Transformation project serves on the WHF advisory board and will continue to influence this important player.

Second, the State Board of Health is examining mental health issues from a public health policy perspective. The Board heard testimony from the project and has joined the partnership. In January, the Board adopted a new strategic plan. One of its goals is to "assure access to critical health services," and one of the objectives under that goal is to "promote access to preventive mental health services." The Board is in the early stages of this work, and its first activity is to educate itself about ongoing mental health reform efforts such as the Mental Health Transformation Grant. Another activity is to support TWG activities that take a public health approach. Ultimately, the Board expects to produce a report that "examines capacity in the state to deliver preventive, community oriented, population-based mental health services, articulates a vision for a public health approach to mental health, and makes policy recommendations."

The DASA Prevention Program has received a five-year grant to advance mental health problem prevention

In addition to the Prevention Advisory Group work, the state enjoys and benefits from the work of the Division of Alcohol and Substance Abuse's (DASA) prevention program. The program coordinates with the Department of Health, the Department of Community, Trade and Economic Development (community mobilization), the Office of the Superintendent of Public Instruction (OSPI) and others facilitating the Risk/Protective Factor framework in this state; this expertise has merit for mental health prevention.

In October 2004, Washington received a State Prevention Framework-State Incentive Grant (SPF-SIG) through the Center for Substance Abuse Prevention for $2.35-million per year for five years through DASA. Since multiple risk factors are addressed in strategies to prevent under-age drinking and substance related conditions, the project will serve as both a model and an entry point towards advancing mental health problem prevention. Through the SPF-SIG, DASA will contract with local community applicants to implement the strategic prevention framework, including local assessment of need, resources, and readiness. Once a community has moved through these first three assessment steps, it will be allowed to select and implement programs that can serve as a model framework for future Transformation prevention strategies.

Policy Potential

As Transformation discussions take shape with agencies involved in the project, attention often turns to prevention. It is apparent that years of funding services for the most in need has created a "mental illness" system; not a mental health system. The group and its audience, the TWG and agency policy leaders, recognize the importance of more clearly defining mental health, linking it to physical health, and focusing on a public health approach for creating healthy individuals, families and communities. With increasing focus on these aspects of Transformation, there is a growing understanding of policy implications for the State's mental health system. Questions asked regularly by key policy makers include: Is mental health really being addressed? How can the health of Washington's citizens be addressed without including mental health? Do we have the right governance structure to advance a model that is preventive? Should we develop a more coordinated approach to prevention by establishing an Executive Policy Manager in the Governor's office to ensure coordination across state agencies? The Transformation Project Prevention Advisory Group will clearly play a significant future role in addressing these policy questions.

This section of the report has not been reviewed by the TWG as of this date. It will be presented at the August 25, 2006 meeting.

CHAPTER 5:

EVALUATING THE TRANSFORMATION OF MENTAL HEALTH SERVICES IN WASHINGTON

OVERVIEW

The evaluation of the Washington State Transformation *(Partnerships in Recovery)* will follow the evaluation plan originally submitted in Washington State's proposal. The planning activities of the first nine months of the grant have not substantively altered the original plan and the primary components remain in place as originally proposed. Although some minor revisions to components of the plan have been introduced to attain efficiencies not apparent when the proposal was written, the approach remains essentially unchanged. The text that follows outlines the evaluation plan for the State's Transformation, explaining these minor revisions and describing the more detailed evaluation planning leading to the current version of the evaluation plan.

As stated in the original proposal, the primary purpose of Partnerships for Recovery's evaluation will be to provide information useful to managing the Transformation and to hold those involved accountable to the outcomes specified in this proposal. Secondly, the evaluation has been designed to ensure accountability to SAMHSA for performance and outcomes of the Initiative. The proposal stressed the following:

- **The evaluation process will be consumer and family driven**. Consistent with the President's New Freedom Commission on Mental Health, the evaluation plan for system transformation in Washington State ensures that both adult and youth consumers and their families play active roles. Through establishing a Consumer Evaluation Subcommittee and a Family Member Evaluation Subcommittee and through representation on all committees and workgroups, the input of consumers and family members will drive all facets of the evaluation process.
- **A transformed mental health system centers on development of an infrastructure that allows consumers, family members and other stakeholders to monitor progress, evaluate outcomes, and assess the need for mid-course corrections**. Implementing and sustaining large-scale changes in the way state and county agencies do business requires a multi-agency database and a capacity to use data to inform multiple stakeholders and guide implementation.

The evaluation process will have three principle components.

The principle components of the evaluation process include:

1. Development and Implementation of Government Performance and Results Act (GPRA) measures;
2. Collection and reporting of SAMHSA's National Outcome Measures across all agencies engaged in the transformation; and
3. Implementation of a Theory of Change evaluation to assess the overall impact of the Initiative on achieving the six original goals of the President's New Freedom Commission and two goals on employment and housing added by Washington State's Transformation Work Group.

The primary responsibility for the evaluation will remain with the Transformation Grant staff, who will coordinate the work with the primary contractors for this project:

- DSHS, Division of Research and Data Analysis
- DSHS Division of Mental Health Research Division
- The University of Washington, Division of Justice and Health Policy
- The Cecil G. Sheps Center for Health Services Research, University of North Carolina-Chapel Hill

The Transformation effort in Washington State spans many aspects of public heath, requires data and input from multiple cross-agency sources, attempts to incorporate consumers and family members in new ways, and creates new partnerships for evaluation of mental health services in the state. With this ambitious agenda it was decided in the original proposal planning that no one entity could address all evaluation fronts simultaneously. For these reasons, this consortium of state agencies, local and national experts in systems change evaluations, has been assembled for the evaluation effort.

Evaluation Task Group Recommendations

A more detailed level of evaluation planning occurred in April and May 2006. Evaluation was one of six Task Groups established by the Transformation Work Group (TWG). (See Appendix 6 for a list of Evaluation Team members.) While other task groups relied on expertise recruited from the appropriate professional communities, we utilized the existing evaluation team, including the

Family and Consumer Education Team (FACET) members to perform this planning effort for the evaluation. This ensured that consumers and family members were a central part of the critical planning effort, and they were central to the process. The goal of the group was to consider the Transformation activities to date, including the articulation of Transformation outcomes and to further develop the evaluation plan, beyond that articulated in the original proposal. As has been the case for several of the other Task Groups, it is difficult to plan an evaluation until some specific program and policy changes are identified. Following the lead of the other Task Groups, the Evaluation Team articulated a set of five recommendations that would further guide the evaluation effort as specific changes are pursued in the planning and Transformation process:

Recommendation 1

– As part of the Comprehensive State Plan, a logic model should be developed that will guide the ongoing evaluation of the Transformation effort. It should include Transformation goals and activities, inputs and outcomes.

– This logic model would be embedded in the evaluation plan.

Recommendation 2

– The Transformation Workgroup should frequently review data and results produced by the Evaluation Team to inform and guide development, implementation, and sustainability efforts.

– Evaluation Results should be regularly publicized and easily accessible to the general public.

Recommendation 3

– Build the capacity of consumer-run programs to participate in self-evaluation, and to contribute to the Transformation Grant evaluation.

Recommendation 4

– The evaluation should measure both process and outcome changes, and examine both consumer and system level components

Recommendation 5

– The Evaluation Team will develop and submit to the TWG for review an evaluation plan based on the final strategies outlined in the Comprehensive State Plan.

It will be important for the Comprehensive State Plan to prioritize the strategies and put them in sequential order for implementation.

Consumer, Family, and Youth Involvement in the Evaluation

The evaluation process for the Transformation effort provides one of the avenues for investing consumers, youth and family members with decision-making powers over Transformation activities and outcomes. The original proposal identified several mechanisms to accomplish this goal. The original plan was to establish two evaluation subcommittees, one for Families and Youth and one for Adult/Older Adult consumers. These committees will review all proposed evaluation activities and findings to determine if they are responsive to consumer- and family member-identified concerns and address cultural issues. Membership of the two subcommittees will come from individuals nominated by statewide and local consumer and family member groups and by providers. The proposal also identified a FACET that will be integral to all evaluation efforts, and that would participate fully in determining the responsiveness of the Transformation to consumer voice and concerns, recovery, and cultural sensitivity. The original proposal did not clearly differentiate the role of these committees, and was not clear or whether the committees overlapped in membership, scope and responsibility.

Given this ambiguity, the Transformation Staff in consultation with the evaluation partners, formed a single committee, the FACET, and centered the responsibility for consumer and family member involvement in the evaluation with this group. This was done to facilitate progress and to maximize the input of consumers with evaluation professionals early on in the process. The formal definition of FACET is:

> *The team of consumers, family members and youth that participate with research and evaluation professionals on to the MHTP Evaluation Team to conduct required evaluation activities for the grant. FACET membership will be comprised of no less than six consumers as defined above, and the two half time consumers employed by the University of Washington for this project. The total membership of FACET should include no less than four adult consumers and no less than four parents/legal guardians, should contain representatives of both Eastern and Western Washington, urban and rural areas, and represent the ethnic diversity of the state. The contractor shall consult with MHTP consumer staff in selecting members for FACET, and obtain their approval in finalizing membership*

for this group.

FACET team members were named in February 2006 and the team currently consists of 10 consumers and family members. These individuals, the evaluation partners, and MHT staff have been meeting twice monthly since

February 2006, to complete the planning and execution of Transformation activities.

The Evaluation Task Group also planned a series of training events intended to increase the skills and knowledge of consumers and family members regarding the evaluation. Beginning in the second year of the grant, the evaluation team will work with consumer groups, and the consumer network development team to identify evaluation studies that are germane to the concerns of consumers and families and may not be addressed by the main evaluation design. “Mini” contracts will be made available to family and consumer organizations to conduct small evaluation studies on these topics. Up to $10,000 is expected to be set aside each year of the grant, to be made available to consumer groups to directly evaluate their own programs. The evaluation team will be responsible for making funding decisions, with the University of Washington contractors responsible for designing the grant application process.

Together with Partnerships for Recovery staff and other consultants, our goal will be to create multiple roles for consumers and family members in evaluation, to establish roles with significant decision making authority, to actively employ these individuals in the enterprise and to create learning paths and career development opportunities for those interested in this work. This approach to the role of consumers and family members in evaluation represents a significant departure for Washington State, and demonstrates a clear commitment to consumer and family member voice in the Transformation.

Existing Resources and Approaches to Data Collection

Consistent with the President’s New Freedom Commission Report, Washington State has long recognized that persons with serious mental illnesses or serious emotional disturbances may have contact with a broad range of non-mental health settings (e.g., adult or juvenile justice, education, child welfare, vocational rehabilitation, Medicaid). In response to this recognition, and prior to the SAMHSA State Transformation RFA, administrators and policy makers in Washington State recognized the

importance of improving screening and referral processes and coordinating services provided across DSHS. To this end, the state established a centralized Research and Data Analysis (RDA) division within DSHS that has access to and coordinates data from across multiple divisions. RDA has constructed a central research database that matches client service records from sixteen different data sources that record child and adult service, authorization, and management information. This technology allows RDA to record the DSHS services used by children and adults who are mental health consumers over time, the cost of those services, contact information, and consumer demography. This central research data warehouse, known as the Client Services Data Base, or CSDB, is then used to provide data for service integration initiatives across the department. The development of the CSDB is critical to creating the foundation for present and future system transformation. With additional enhancements, it will play a critical role in continuous quality improvement feedback and provide information to support the management of Transformation.

In addition to these data, the Mental Health Division of DSHS routinely collects the following data to monitor and analyze the performance of the Washington State mental health system. These data come from a combination of the following five data systems for mental health services and surveys:

- The Mental Health Division Consumer Information System
- The State Psychiatric Hospital data base Health Integrated Information System
- The Medicaid Management Information System payment database
- The Mental Health Statistics Improvement Project, Youth Services Survey, the Youth Services Survey for Families; and the Adult Consumer Survey
- The Department of Social and Health Services, Research and Data Analysis (RDA) Client Services Database (CSDB; described above)

The survey data is based on statewide surveys conducted by the Washington Institute for Mental Illness Research and Training (WIMIRT) for the Mental Health Division. Copies of the survey reports are available at the Mental

Health Division's website
http://www1.dshs.wa.gov/Mentalhealth

or on WIMIRT's Webpage
http://depts.washington.edu/wimirt/Publications.htm.

Information and Data Infrastructure Enhancements Planned

The Transformation Grant allows expenditure of funds for a number of infrastructure enhancements. Data infrastructure enhancements will be crucial to the evaluation of the Transformation, and these enhancements will constitute a key activity in transformation work at the policy, practice and evaluation activities over the life of the grant. Washington State will implement an array of enhancements to Washington's information infrastructure that are designed simultaneously to support the evaluation, guide the Transformation process, and provide information and accountability to consumers and policy makers. Elements of this Infrastructure will include:

- Expansion of the RDA Research database to include additional outcome measures, targeted to provide reporting on the SAMHSA National Outcome Measures and on elements of the GPRA related to direct consumer outcomes.
- Expansion of the consumer satisfaction surveys to include a greater range of outcome measures and to survey mental health consumers who are served by non-MHD systems.
- Implementation of additional surveys to track population and consumer trends in attitudes toward mental illness, stigma, help-seeking behaviors, consumers' perceptions of transformation activities and population-level outcomes.

Data infrastructure enhancements are allowable Transformation Grant expenditures. Although not directly a part of the program evaluation budget, the enhancements planned will be critical to the overall success of the evaluation. Key enhancements underway, in planning stages, as well as broader enhancements being considered, are outlined below.

Specific Data Infrastructure Enhancements Planned—

The Mental Health Transformation Grant will support, over the life of the grant, a significant expansion of DSHS data infrastructure through the development of new data sources, data tables, outcome measures, and reporting processes. Infrastructure development will include:

Core Infrastructure Changes Are Underway

- Processes to capture on an ongoing basis new information (both internal and external to DSHS) on the **use of and need for mental health services,**
- Processes to capture on an ongoing basis new **client outcome data,**
- New tools to measure **quality of mental health services** provided,
- New analyses to measure the **impact of mental health services on client outcomes**, and
- New **reporting processes** to meet grant and program requirements.

The activities in the first project year ending September 30, 2006 include:

1. Developing new longitudinal client-level RSN service tables organized around State Plan mental health service modalities.
2. Developing new longitudinal client-level medical claims diagnosis tables organized around RSN access-to-care standards.
3. Developing longitudinal client-level data tables capturing indicators of need for mental health services from new source systems:
   a. Medical Assistance Healthy Options encounter data,
   b. Economics Services Administration Barcode incapacity data, and
   c. Aging and Disability Services Administration CARE functional assessment data.
4. Identification of non-MHD service categories in existing DSHS data sources that reflect the provision of and/or need for mental health services; development of longitudinal client-level data tables summarizing these service encounters.

Data Infrastructure Enhancements Planned—-Data Needs Outside DSHS for Mental Health Transformation Monitoring and Evaluation

Several questions cannot be answered at all with the current system of data silos.

- How many low-income consumers are we serving overall, across all government agencies?
- How much are we (government) spending on their mental health services?
- What mental health service modalities are they receiving from government?
- Are they receiving government-sponsored help with employment, job training, and housing?

To answer those questions, we need to match consumers receiving mental health services across agencies – especially the other TWG agencies. Currently, we match within the DSHS, but not across the other agencies.

As a next step we need to gather information on the mentally ill persons served, the mental health service modalities provided, costs and dates, from the following state agencies, other government entities and/or programs and services:

- Health Care Authority (requires analyzing encounter data)
- Department of Veteran's Affairs
- Department of Corrections (Prison data)
- City and County Jail data (through the new WASPC data or through our 1290-related data)
- Tribal clinics and Indian Health Services
- Veterans Administration (federal)
- Medicare-Medicaid Dual Eligibles (need the Medicare services)
- Public Schools (if possible)
- Charity hospital care from Comprehensive Hospital Recording System
- Medicaid Management Information System (Drug Pharmacy Formulary)

Data Infrastructure Enhancements: Anticipated Activities in Years 2 Through 5

In subsequent years we anticipate using MHTP resources for the following purposes:

- Ongoing maintenance of the new data tables developed in the first year of the grant.
- Developing longitudinal client-level data tables capturing stability in housing and living arrangements using homelessness and household composition information from the Automated Client Eligibility System.
- Developing longitudinal client-level data tables capturing employment outcomes measured in Employment Security Department earnings data.
- Developing longitudinal client-level data tables capturing standardized measures of access and quality of care that can be derived from administrative data; for example, specific HEDIS measures including quality of psychotropic medication management and follow-up after hospitalization for mental illness.
- Developing access to student-level school outcome data maintained by the Office of the Superintendent of Public Instruction.
- Developing mental health treatment need indicator tables from CAMIS (Children's) and CATS (JRA) information systems.
- To the extent feasible, developing data tables other data sources external to DSHS such as the Veterans Administration, local jails, and housing programs.
- As requested by project staff to support Transformation Grant activities, performing analyses and reporting information describing medical service use, service need, and client outcomes
- Providing longitudinal client-level data tables, documentation, and consultation to the Mental Health Transformation Grant evaluation team

Transformation Evaluation Activities

The grant team will expand current data and evaluation capabilities to address GPRA indicators as well as SAMHSA's National Outcome Measures (NOMS) to assess overall system performance. The GPRA indicators will be

collected, managed, analyzed, interpreted, and reported to monitor, guide and evaluate the process of the evolving Transformation. The collection, management, analysis, and interpretation of the NOMS will assess the impacts of the evolving transformation (i.e., who, what, when, where, and how) on individual consumers and their families. These activities are described below.

Development and Reporting of Government Performance and Results Act (GPRA) Measures

The following steps will be taken to ensure Washington State's ability to collect and report on the GPRA measures:

Step 1: A GPRA workgroup will be convened from the membership of the Evaluation Team.

Step 2. With MHD, RDA, and MHTP staff leadership, the GPRA Workgroup will develop a comprehensive plan to measure and report required GPRA measures and to propose GPRA measures unique to the state of Washington.

Step 3. The GPRA Workgroup will submit the recommended GPRA measures, annual performance targets, and budget implications, and make a recommendation to the TWG.

Step 4. The TWG will finalize the GPRA measures and approve procedures to collect and report on the measures. These will then be submitted to the SAMHSA Project Officer for review/approval.

Step 5. GPRA and related performance measures will be reviewed by the Evaluation Team and at regular TWG meetings. They will be modified, if needed, by the TWG using the process described in the steps above, in coordination with SAMHSA Project Officer and the coordinators of SAMHSA's national field evaluation.

These steps will allow the Partnerships for Recovery to monitor the process of the Transformation using GPRA outcomes for all six of the goals of a transformed mental health system as outlined by the President's New Freedom Commission on Mental Health. GPRA outcomes will be collected and reported as required by SAMHSA.

Initial GPRA Measures Plan

Because SAMHSA's cross-site evaluation contract has not been finalized, we cannot define precisely how we will collect GPRA data for the project. We must await SAMHSA's final instructions before proceeding. However, the Evaluation Guidance document provided by SAMHSA does permit development of an initial GPRA data collection plan. Our initial plan is presented as a draft below.

The seven required GPRA measures are:

1. Percentage of policy changes completed as a consequence of the Comprehensive Mental Health Plan.
2. Number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the Comprehensive Mental Health Plan.
3. Percentage of financing policy changes completed as a consequence of the comprehensive Mental Health Plan.
4. Percentage of organizational changes completed as a consequence of the Comprehensive Mental Health Plan.
5. The number of organizations that regularly obtain and analyze data relevant to the goals of the Comprehensive Mental Health Plan.
6. The number of consumers and family members who are members of statewide consumer– and family–run networks.
7. The number of programs that are implementing practices consistent with the Comprehensive Mental Health Plan.

Washington State's initial plan to operationalize and collect these data is contained in Table 1 beginning on the following page.

TABLE 1 - GPRA MEASURES

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
1. Percentage of policy changes completed as a consequence of the Comprehensive Mental Health Plan	Require participation of all agencies in partnership with the Mental Health Transformation Project to report the percentage of all policy changes as a result of the approved strategies by the TWG	GPRA Monthly Monitoring Report Who is your WAC Coordinator/or P&P person? Any RCW/WAC/P&P changes in period?	
2. Number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the Comprehensive Mental Health Plan	Require all agencies in partnership with the Transformation Project report the number of persons and related workforce who have been trained in service improvement recommended by the Comprehensive Mental Health Plan	Listing of Training Events By events, sign in sheets Count of participants by: Demographics Consumer status Employed by: Others First example is the CTP (Community Transformation Partnership) Recovery and Resiliency Training	
3. Percentage of financing	All Require all agencies in	GPRA Monthly Monitoring Report	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
policy changes completed as a consequence of the Mental Health Plan	partnership with the Transformation Grant to report the percentage of financing policy changes completed as a consequence of the Mental Health Plan	1. Who is your WAC Coordinator/or P&P Person? 2. Any RCW/WAC/P&P changes in period?	
4. Percentage of organizational changes completed as a consequence of the Comprehensive Mental Health Plan (includes interagency agreements)	All agencies in partnership with MHTP are required to report the percentage of organizational changes completed as a consequence of the Mental Health Plan	3. Are there any organizational changes relevant to CMHP in period? 4. Are there any MOU's changes relevant to Mental Health in period?	
5. The number of organizations that regularly obtain and analyze data relevant to the goals of the Comprehensive Mental Health Plan	MHTP staff and the Evaluation Team will research the number of organizations that regularly obtain and analyze data relevant to the goals of the Comprehensive Mental Health Plan.	5A. Is your organization regularly collecting data relevant to the CMHP? 5B. Is your organization regularly analyzing data relevant to the goals of the CMHP? Develop a monitoring tool to obtain information from: **State Level** State Agencies Regional Level Regional Support Network	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
		Consumer Organizations Other Non-Profit Organizations Develop a monitoring tool to obtain information from: **<u>Consumer Level</u>** PAVE, NAMI, SAFE, AND NEW CENTURY Coalition, CTP and those yet to be developed statewide organizations Develop a Monitoring Tool to obtain information from: **<u>Local Level</u>** State Administrators Regional Support Network Local Providers	
6. The number of consumers and family members who are members of Statewide consumer - and family – run networks	MHTP Staff will establish a list of consumers and family members who are members of statewide consumer and family – run networks.	Listing of all statewide consumer and family member organizations. For each: **Roster of membership** **Count of participants by**: Demographics	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
		Consumer status Employed by etc. Others…. First example is the CTP (Community Transformation Partnership) Recovery and Resiliency Training Develop a monitoring tool to obtain information from: **Consumer Level** PAVE, NAMI, SAFE, AND NEW CENTURY Coalition, CTP and those yet to be developed statewide organizations	
7. The number of programs that are implementing practices consistent with the Comprehensive Mental Health Plan	All agencies in partnership with MHTP are required to report the percentage of organizational changes completed as a consequence of the Mental Health Plan	Develop a Monitoring Tool to obtain information from the **Local Level** State Administrators Regional Support Network Local Providers Develop a monitoring tool to obtain information from: **State Level** State Agencies	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
		Regional Level Regional Support Network Consumer Organizations Other Non-Profit Organizations Develop a monitoring tool to obtain information from: **<u>Consumer Level</u>** PAVE, NAMI, SAFE, AND NEW CENTURY Coalition, CTP and those yet to be developed statewide organizations	

Operational Definitions on how to count GPRA Measures will be collected in Washington State

For Policies and Procedures that change in the grant period, number that:

1. Change as a direct result of Comprehensive Mental Health Plan (mandated change)
2. Change associated with Comprehensive Mental Health Plan
3. Change results indirectly from the Comprehensive Mental Health Plan
4. Complementary change that might be enhanced by CMHP

$$\% = \frac{\text{Numerator}}{\text{Denominator}}$$

(N) Count of:
1. RCW
2. WAC
3. State Agency Policy
4. Local Policy

(D) Count of: Policies related to Mental Health within each administration: (total of 1, 2, 3, and 4))

Levels:
1. Governor – State Initiatives
2. State Agency Secretary
3. DSHS Administration Assistant Secretary
4. Division Director
5. Local policies (broadly speaking)

Scope: Only TWG Agencies Representative – Administration/Division

National Outcome Measures (NOMS)

In addition to the GPRA Infrastructure Indicators, the RFA specifies that improvements in State performance on the SAMHSA NOMS will be expected as a long-term result of the grant program. The NOMS are listed below.

1. Decreased mental illness symptomatology/increased level of functioning
2. Increased or retained employment and school enrollment/school attendance
3. Decreased involvement with the criminal justice system
4. Increased stability in family and living conditions
5. Increased access to services/number of persons served

by age, gender, race and ethnicity

6. Decreased utilization of psychiatric inpatient beds/readmission to a State psychiatric hospital at 30 and 180 days
7. Increased social support/social connectedness
8. Increased positive reporting by clients about outcomes
9. Increased cost effectiveness
10. Increased use of evidence-based practices

An important limitation of the URS data is that the NOMS are reported only for people served by the State Mental Health Authority (SMHA). A critical concept of Transformation is that all agencies, and not just the SMHA, should participate in improving the accountability, capacity, and quality of services for people with or at risk for serious mental illnesses or serious emotional disturbances. In keeping with this vital concept, to most effectively measure the impact of transformation on client outcomes, NOMS data must be collected from all relevant agencies.

Specifically, Washington State will expand its data collection strategy to routinely collect NOMS data from all identifiable service recipients in Washington State, not just those served by the Mental Health Division. We will begin this work by including in our first year survey, all adults with mental health diagnoses being served in all eleven administrations of DSHS. We will expand the scope of NOMS surveying in the Years 2 through 5 to include children and family, and those hitherto unknown to DSHS, but who have identified mental health problems.

Recovery and Resilience

A requirement that states measure and report recovery and resiliency was issued in SAMHSA Guidance for the Evaluation of Transformation. That document specifically stated:

> *In order to determine whether transformation has met its goal of facilitating recovery, the national evaluation will help each SIG State to select and use one recovery outcome instrument and one service system recovery-facilitation process instrument to measure their recovery results. We would expect substantial consumer involvement in selecting the recovery measures and in collecting data on recovery. The*

national evaluation will also examine whether corresponding information on resilience can be captured.

As with the GPRA and NOMS data, we would not expect to see measurable effects on the recovery and resilience measures immediately. Most States are not currently quantitatively assessing recovery, and significant data infrastructure development will be necessary in order to institutionalize these measures Statewide. Moreover, our transformation theory predicts that the recovery-orientation of a system will follow institution of the infrastructure changes, which will take some time to implement. We would not expect to see measurable change in the recovery-oriented service systems measures, therefore, until at least the end of year 3 of the grants. Changes in client-level recovery outcomes may not occur until after the grants have ended.

The evaluation team in Washington State decided in the first year of the grant to pilot test the Recovery Oriented System Indicators, one of the recovery measures listed in the compendium offered by HSRI. We have completed a first year pilot of that instrument, found it to be of value, and will make the case that it serve as an acceptable measure of recovery for Transformation States. A report of those findings will be available from project staff in the near future.

Resource Inventory and Needs Assessment

The Resource Inventory and Needs Assessment completed as part of the Evaluation Team's first year of work is included in Appendix 2. That detailed report used multiple methods to identify need and resources available in the state, and has many uses for planning transformation efforts. In terms of evaluation, the principle findings from this report serve to refine the focus of the evaluation, and will constitute place markers for the logic model to be developed. Principal findings from that study fell into four categories:

1. **Expand access to mental health care, to reduce unmet need and to ensure that consumers are served when the problems first manifest themselves.**
    - This may include changing benefit designs to maximize federal match and get more matching dollars, and working to maximize third party reimbursements. Should also include reducing and

simplifying the record-keeping burden for providers, which would save funds throughout the system.
- May also include closing hospital wards to transfer some funds into community services.
- It may also mean some new state funds, since it seems unlikely that the above steps will save enough in the short-term to serve twice as many people as DSHS is serving now.

2. Change community treatment options for all consumers to emphasize recovery, consumer choice and improved outcomes.

- Attend to cultural and geographic subgroups here as well as consumer choice generally – one set of services does not fit all consumers.
- This set of changes alone should improve recovery outcomes and may generate cost offsets in psychiatric hospitalizations, medical costs, and criminal justice costs.

3. Reduce stigma and improve public knowledge about mental illness, treatment options and recovery.

- This is important for every group of consumers – it may be particularly important for people with co-occurring health problems, people who are homeless or in jail or prison, and children and youth.
- This should improve recovery outcomes – it may also enhance potential cost offsets in psychiatric hospitalizations, medical costs, long-term care costs and criminal justice costs.

4. Integrate and coordinate services more effectively for clients with multiple problems.

- This is very important for the wellbeing of consumers, more than half of whom report encountering discrimination and stigma.
- This too is important because the first treatment and referral source for mental illness will always be families and friends in the community.
- Community and family members need to know how common mental illness is, that effective community based treatment is available, where it is, and that it works!

Theory of Change Evaluation

The Evaluation Team will utilize all that was learned in the first project year to develop a complete logic model, with activities, timelines, and benchmarks clearly specified. Then in Years 2-5 the Evaluation Team will conduct an

impact evaluation using a theory of change evaluation approach. The evaluation will assess long-term outcomes addressing the eight goals adopted for this project (the President's six New Freedom goals, plus the employment and housing goals adopted in Washington State by the TWG. The areas of need identified through the Resource Inventory and Needs Assessment will also be essential components of an articulated theory of change for the Transformation.

Elements to consider. An integral part of the logic model/theory of change for this evaluation will consider the elements suggested by SAMHSA in their Evaluation Guidance Document, for the focus of the model. The following were suggested by SAMHSA as likely candidate processes that might contribute to successful organizational change in Transformation. Each will be carefully considered in constructing the model:

- leadership
- workforce competencies
- workforce training and development efforts
- effectiveness of incentives
- organizational readiness and culture
- interagency policy and standards alignment
- integration of mental health-related data across agencies
- performance indicators
- effectiveness of quality assurance mechanisms
- consensus building among stakeholders
- goal achievement
- needs assessment
- interagency collaboration (e.g., number of meetings/conference calls among diff agencies for each goal)
- barriers encountered and how resolved (e.g., see identified barriers from the New Freedom Commission Final Report, Executive Summary, p. 23)
- resource flexibility
- contract expectations
- values orientation
- public/private partnership/relationship
- impact of economy and financing cuts on MHT efforts
- interim steps in making infrastructure changes, e.g., meetings held, agreements reached, etc.
- impacts of MHT on other agencies and impacts of other agencies on MHT; how MHT is taking its place in the consortium of other interests

- inclusion of consumers in above areas

The four principle areas of findings from the Resource Inventory and Needs Assessment (see Appendix 2) will also constitute key elements (inputs, outputs, processes in the construction of the model.

Focusing on many of the processes above, the following issues will be addressed in the logic model that will serve as the articulated theory of change for this project. That document and model will then guide evaluation efforts over the life of the evaluation. Among the questions to be addressed, the listing below is offered as an initial scope and purpose of the evaluation. Finalization will occur after the TWG and participating agencies and stakeholders come to consensus about the directions that Transformation will take. Thus the suggested topics below are preliminary:

1. ***The need for mental health care.*** How many people have been screened or served somewhere in DSHS in ways that indicate a "need" for mental health services? What is their age, gender, race, ethnicity and location?
2. ***Mental health service use and costs across systems***. How many consumers needing treatment used mental health services from DSHS? How many from MHD, how many from other parts of the agency? Were the rates and patterns of mental health service use different for different subgroups of people? What kinds of mental health services were used, and what did they cost? How many consumers needing treatment accessed services through non-mental health settings? How well were their needs and preferences met?
3. ***Mental health service cost offsets***. How do non-mental health costs across DSHS compare for those who received various sorts of mental health services, including "no treatment." Are there state costs to NOT serving people, which could be used to expand treatment?
4. ***Mental health service outcomes for consumers and families***. How did various groups of people needing and/or receiving mental health treatment fare in their daily life? How do the groups compare in employment and wages, school enrollments and success, arrests and convictions, and use of medical care? How do consumers and family members feel about the way they were served? Did they report being

involved in individualized planning for their services and supports?

Sound quasi-experimental designs, econometric analyses, multi-level modeling and structural equations will be used to answer critical questions about the macro-level impacts of mental health transformation. The questions include but are not limited to:

- How do the mental health outcomes for child and adult consumers compare before, during, and after the transformation?
- How do community outcomes for mentally ill persons detained in jail (e.g., public health and public safety) compare before, during, and after the transformation?
- What are the intersystem effects of the transformation with respect to point-of-service entry (i.e., irrespective of entry point, do consumers get appropriate services?), information sharing and accountability among agencies involved in serving multiple system users, and the alignment of policies and procedures across multiple systems (i.e., criminal justice and Medicaid)?
- What are the costs of these various transformation efforts? Are cost-efficiencies realized from expanded service delivery and in what sectors?
- What regional differences are observed, and how do these relate to regional demographic characteristics, service configurations, funding arrangements, and other ecological factors.

Feedback and Continuous Improvement

The Evaluation Team (with the consumers, family members and youth an integral part), will report, evaluate, and synthesize evaluation findings on an ongoing basis to the TWG throughout the Transformation process and beyond. These findings will be disseminated in series of reports, presentations, and web mediums among consumers, family members, advocacy groups, key stakeholders, administrators, and other constituents in order to facilitate dialogue about the Transformation's processes and impacts. This dialogue will be used to re-shape, re-focus, and modify the Transformation.

CHAPTER 6:

SHIFTING THE PARADIGM

This first year of the MHTP has been devoted to developing a shared understanding and common agenda for Transformation. The outcomes and strategies presented to the TWG provide the direction and form the vision underlying this CMHP. The responsibility of converting these visionary action plans into reality rests with the Transformation Partners. The TWG and the MHTP staff will be working in Year 2 and beyond to facilitate and support participating agencies in their efforts to translate the vision into concrete actions.

The MHTP team has been working closely with staff in partner agencies to inventory the efforts already planned or under way that help to move the Transformation agenda forward, starting first with a review of state agency strategic plans recently submitted to the Governor. Agencies have told the Transformation Project staff that there are many activities they are involved with that are not listed in their strategic plans. We will inventory these strategies for inclusion in next year's plan.

Also, state agencies are currently developing budget requests and proposed legislative packages for the 2007-2009 budget period. By September, the agencies will submit these requests to the Governor's Office. Because of the need to finalize the Comprehensive Mental health Plan by early September, these budget/legislative requests will not be included in the first year's plans. Once we know what is incorporated into the Governor's legislative package, and which items are supported by the Legislature, a more accurate gap analysis between what the community recommendations are and what agency activities are planned. Once that is done, the state will have a better idea about where to focus its resources to address community recommendations.

It is apparent that years of funding services for the most in need has created a "mental illness" system; not a mental health system. The TWG, consumers, families, partner agencies, and policy leaders, recognize the importance of more clearly defining mental health, linking it to physical health, and focusing on a public health approach for creating healthy individuals, families and communities. With increasing focus on these aspects of Transformation,

there is a growing understanding of policy implications for the state's mental health system. In Year 2, the TWG will engage all Transformation Partners in a crucial discussion about how and when a systemic redesign of the system of providing mental health services in Washington will occur.

SUMMARY

If we are to achieve our objectives related to improving the health of all individuals and families residing in Washington State, we must have a strong vision. The Washington Health Foundation is on the right track with their "Healthiest State in the Nation Campaign." Key organizations must come together, agree on a vision, establish cross system goals/objectives, identify a core set of outcome measures to track our progress and focus our resources in such a way as to provide more holistic services to individuals and families.

In our quest to raise the bar regarding improving the health of all citizens, we must broaden our philosophical approach to include mental health as an essential component of overall health. It is imperative that we acknowledge the interrelationships of mind, body and spirit. When we talk about health we must incorporate the spectrum of medical, mental health, alcohol/drug and related health areas. By viewing health in this broad fashion, our planned interventions will become more holistic and effective. We cannot continue the traditional piecemeal approach in which partial services are rationed to those in most desperate need, and expect peak results.

Governor Gregoire and the Washington State Legislature have recognized that our young children are our greatest assets. If we do not prepare these children for adolescence and adulthood, we will face tremendous social and economic costs well into the future through poor academic achievement, increased criminal activity, unprepared and untrained workforce, family strife, poor mental health, increased alcohol/drug use and overall decreased health of our families. On the other hand, if we focus more attention on being preventive in our approach and are more holistic in our strategies to assisting families in developing healthier lifestyles, then we can reduce the cost of more expensive government services in the long term.

The Mental Health Transformation Project leadership agrees with the vision of making Washington state the Healthiest State in the Nation and we believe that the state must place much more emphasis on prevention and early intervention as well as cross system planning if we expect to improve the health of our residents. Improved health of citizens will in the long run result in less demand on publicly funded health and mental health care systems. At the same time, our subcommittees' work reflects that our current system of care, while expensive, is inadequate. We don't purchase enough of the needed services, in some cases purchase services that aren't wanted or valued, and have an evolved benefits package in public mental health particularly where only the most ill citizens qualify, and usually require the most costly care, draining limited financial resources. Our subcommittees have articulated through their hard work, a strong set of recommendations for addressing the ills of the current system.

The Transformation Grant Team recommends a dual approach, one effort seeking system improvements, recommended by the subcommittees; the other addressing prevention and health promotion, recognizing that failure to address these issues dooms the state to make patchwork improvements to the current system, only on the margins. The challenges are many. The resources are limited. If Washington is to become the healthiest state in the union, it will require a commitment to both: To prevention, early intervention and health promotion, AND to improvements in the current system. True transformation can only occur if we do both.

Reviewing the work of the past year, six major forward-looking themes have emerged that should infuse and guide the work of the MHTP in Year 2 and beyond.

Transformation Theme 1:

The State of Washington views mental health as part of overall health.

This theme does not necessitate any structural change. Rather it promotes a philosophical approach where mental health is an assumed part of a person's overall health. This supports the contention that health is about mind, body and spirit. The Governor may want to distribute a policy directive or Executive Order

directing this approach. Further, the Legislature may want to pass a resolution supporting this approach.

Transformation Theme 2:

Mental Health is incorporated into existing prevention and early intervention initiatives and more coordination occurs among these programs.

While there have been a variety of prevention and early intervention strategies implemented in Washington State, most have been focused on very specific population groups (preschool, elementary school, youth at risk for tobacco use or substance abuse), few have perceived their charge as broad health initiatives and few have involved workers from the mental health field as part of their planning and policy team. The Governor could create an Executive Policy Position on Prevention and Early Intervention. This person could work with various agencies to inventory prevention/early intervention programs and develop a clear vision with strategies to ensure coordination across these initiatives. And, all of these strategies could follow the approach that a healthy Washington is about focusing on a healthy mind, body and spirit.

Transformation Theme 3:

Following the lead of the Washington Health Foundation, state agencies, with leadership from the Governor, Legislature and Superintendent of Public Instruction, could develop a core set of bench marks (out come measures) to track the health of Washington state residents.

Essentially this theme proposes that Washington State develop an annual report card that tracks key measures that monitor improvements of health status for Washington state residents and compares our progress to that of national benchmarks where applicable. Several state agencies already produce reports using this framework that may simply need to be expanded.

Transformation Theme 4:

State agencies will increase opportunities for consumers/families to establish agency priorities and direction.

The intent here is to ensure systems are more consumer and family driven. While this mantra has been adopted by many health care systems, there has been little or no documentation of how health care

systems have actually included consumers/families in system development or delivery other than conducting consumer satisfaction surveys. State agencies and their contractors must clearly define, as part of their strategic plans, how consumer/family involvement will be increased in the planning and delivery of services.

Transformation Theme 5:

State agencies will improve cross system data collection, data analysis and data reporting systems that focus not only on outputs but report on actual outcomes-reductions in negative consequences and improvements in overall consumer/family/community health indicators.

This theme supports the Governor's Government Management and Accountability Program and encourages agencies to identify cross-system impacts. For instance, what family/individual/community risk factors affect a student's readiness to learn? One has to look beyond classroom size and teacher training. One also has to look at the health (mind, body and spirit) of that individual student and their family/community environment.

Transformation Theme 6:

State agencies, local government, providers, advocates, consumers, and families will make every effort to implement the specific recommendations of the subcommittees. Cross-system collaborations that focus not only on symptoms, but on citizens overall health, wellness and recovery must be paramount if the system is to improve, and we are to reduce negative consequences and improve the lives of our consumers, family members, and our communities.

This theme supports all the subcommittee recommendations and encourages agencies to identify cross-system opportunities for improvement. These efforts support and build upon efforts already underway across all state agencies to improve outcomes, increase voice of consumers and family members in decisions, and develop more effective, efficient, evidence-based and promising programs to the forefront as standard practice in the Washington State network of mental health care.